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ON SMUGNESS[1]

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Some degree of negative response is practically the universal reaction to smug people. To be characterized as smug is never considered a compliment. Such a characterization invariably denotes not only a sense of disapproval but a feeling of active dislike or hostility.

According to the *Oxford English Dictionary* the origin of the word 'smug' is obscure. Originally, its meaning related to neatness or primness in dress. Only during the past few centuries have the current connotations of offensive self-satisfaction, complacency, and self-righteousness become associated with the word. There is, furthermore, an additional, although hardly popular, sense in which the word appears in the literature, i.e., to steal or to grasp, a meaning which some think may be connected with the root of the word 'to smuggle'. In the course of this paper it will be demonstrated how these two very different meanings may be derived from a response to a typical situation in which the prototype of the smug person is regarded as a grasping thief.

The smug person is not actively aggressive or malicious toward others in his smugness. If anything, he tends to be withdrawn and self-contained, undemanding in regard to his environment, and above all, seeming to want or need very little from it. Why so complacently self-satisfied a person should evoke such hostility is not completely clear.

In the course of psycho-analytic practice, however, it is not uncommon to observe patients in whom a most intense hostility and violent hatred are provoked by an encounter with a smug person. The smug object of this outburst may be and often is a relative stranger of no particular significance in the patient's life, a passing acquaintance from some casual social meeting. This fact serves only to accentuate the irrationality of the patient's response, a response whose intensity betrays all the indications of an exaggerated reaction. Both the irrationality and the exaggeration naturally lead to the suspicion of some unconscious determinant for such behaviour. The analysis of such attitudes, furthermore, should reveal not only the significance of the predisposition on the part of certain individuals to react so acutely to smugness (in others) but may perhaps afford some insight into the more common, milder responses felt by most people toward their smug fellows. The phrase 'smugness in others' is used advisedly, for it is by no means unusual for those very individuals who berate the complacently self-satisfied to learn to their chagrin that they themselves have been guilty of creating the impression of smugness in regard to themselves.

Listening to the descriptions which patients give of smug people and how they respond to them, we obtain a strikingly similar picture. Complacency, self-centredness and self-satisfaction are their most prominent attributes. The quality of self-righteousness holds a relatively secondary position, but an important one, especially for certain patients. The sense of self-containment which the smug person imparts is interpreted as a self-centred withdrawal of interest from other persons. The smug person is independent. He seems in need of no one. This element arouses envious fascination. But beyond that the smug person acts as if he were oblivious of his surroundings,

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even unaware of the people in the immediate vicinity, or aware of them only in a general, undistinguishing way. It is this aspect of the smug person which is most intolerable and infuriating to such patients. Their sense of self-esteem is offended; the blow to their narcissism is compounded with a sense of futile and injured rage. The mere presence of a smug person, they complain, is something they cannot endure. They feel in turn angry, inferior, insignificant, and frustrated. Nothing and no one, they say, can impress the smug person. His mind is closed; he cannot learn; he will not change. It is the universally expressed wish of these patients to puncture the barrier of complacent repose, to disturb the equilibrium of self-satisfaction—often by slapping the smug and vapid face, for of all the features of the smug person the facial expression seems to be the most irritating. His countenance is described as clothed with a look of cold, empty haughtiness, or the lips are said to be touched by a very faint, amused smile, as if the subject were enjoying some private communion of self-appreciation.

Several especially articulate patients distinguish between their reactions to the smug and to the conceited person. The latter they regard as a sort of fool, one who pretends to an unjustifiedly exaggerated evaluation of himself, but is by no means convinced in this estimate. It is for this reason that the conceited person tries repeatedly to call the attention of others to his actual or imagined superiority. He needs witnesses to overcome his own doubts concerning his worthwhileness. Not so the smug person; he requires no external confirmation to ensure his sense of self-satisfaction. That is brought about by his own fiat. He enjoys himself publicly, unabashedly, and without concern for the judgement of others. In some instances this last point serves to differentiate the response to the smug from a consciously envious response to successful but generous or modest persons. Such individuals have the good taste, or, perhaps more accurately, are moved by their more highly developed sense of guilt to refrain from giving offence to others by ostentatious self-satisfaction which humiliates the less successful by treating them as if they did not exist. Such people have a regard for others' feelings.

The type of patient to whom the smug person is so sore a trial and the typical derivation of this attitude are illustrated by the following clinical excerpts:

Case 1:

Quite the opposite of the smug person delineated above was Mrs. A. She was an intensely unhappy married woman of 37, who, in spite of a fairly well-to-do economic position, felt poverty-stricken, deprived, and dissatisfied. Although she drove a brand-new convertible car, belonged to a fashionable country club, and sported an attractive French poodle, she identified herself with a rejected Negro child whom she had seen in a movie, a child who had been abandoned in the slums of Harlem. At the beginning of the analysis, which was undertaken for marital discord, social anxiety, and insomnia, her major preoccupation was 'Who snubs me? Whom do I snub?' Her devotion to social climbing was motivated by a need to overcome her social anxiety and strong feelings of social inferiority. For this reason she sought out the company, if not the friendship, of the successful, the famous, and the notorious. She worshipped the secular pantheon of celebrities, seeking to recover her self-esteem through identification with these latter-day demigods. It was indeed her secretly cherished dream that her analysis in one way or another would transform her into her ideal, a Greek goddess of unsurpassable beauty whom everyone would fall down and worship. Such a person would be perfectly poised, composed, and independent. Her love life was dominated by narcissistic object choices of men she thought to be cold, disdainful of others, and aloof.

Her difficulties stemmed from an insatiable oral greediness, which from earliest childhood disrupted her relationships. Her father was a bold, driving, sadistic, and successful man, who, though close to the age of 80, still dominated and humiliated his family, his relatives, and his business associates. The mother was described by the patient as very beautiful but self-centred and selfish. The patient herself was the seventh of eight children—the eldest a girl, then five boys.

When the patient was three years old a sister was born. Following the delivery the mother developed very serious complications which caused her to be hospitalized for many months. During this time the patient was in the charge of her older sister, who doted upon her but who was, nevertheless, an exacting parent substitute. Scarcely had the mother returned from hospital when this sister married and left with her husband for a distant city. This fresh disappointment coming so swiftly upon the heels of her disillusionment in regard to her mother was something which the patient could hardly overcome. Although at this point she turned to her father with furious demands to supply her with all she felt she needed, she continued to yearn for her sister and replaced the object of her affections, now lost in reality, with an identification. In her analysis it was possible to see innumerable ways in which she imitated and identified with her sister, but in her

dreams the object relationship, as it were, was restored. She saw herself repeatedly in the company of her sister (or sister substitute) who fed, dressed, and nursed her. From a strictly statistical point of view more than 75 per cent of the patient's dreams were concerned with feeding and being fed. Variations on this theme were connected with the ideas of sleeping and dying, probably because at the time of the analysis the patient's older sister was already dead. Her fear of poverty represented an unconscious fear of starving to death or of being abandoned, just as her unreasonable demandingness for position and narcissistic supplies reflected her insatiable hunger. For example, when she heard that her husband had been separated from the firm in which he held a partnership, she went to the local grocery and impulsively bought $50-worth of canned food to be stored in the larder. Following this she became elated and, denying her deep-seated fear of starvation, began planning a series of elaborate and expensive dinner parties which she could ill afford.

To compound the insult the younger sister developed into a very beautiful child, the delight and pet of the entire family. Each year the patient celebrated the birth of this younger sibling by getting depressed. In connexion with one of these episodes the patient recalled that, as a child, she had hurled a cat out of a window and killed it. She unconsciously identified her adopted daughter with her younger sister, persistently making slips of the tongue in which she interchanged their names. Her attitude towards her daughter was a mixture of identification and ambivalence. When identified with her she could refuse her no demands, and no criticism directed at her daughter from whatever source would be countenanced. On the other hand, she would expect her daughter to epitomize in reality all the qualities which she herself prized. She was at the same time capable of extreme callousness and cruelty towards her daughter, compensating for this by various acts of ingratiation and self-punishment. From her husband she expected an all-giving mother-father image from whom she would passively receive various token substitutes for the breast-penis to help her achieve once more the golden age of her childhood, before the birth of her sister, when she enjoyed a sense of narcissistic fusion with the mother, a sense of complete passive gratification which admitted of no rival. The patient acted out the impulse to be breast-fed by unconsciously seducing her eight-year-old daughter to suck at her breast.

Mrs. A. experienced a violently rageful reaction when she met a smug but beautiful girl married to a wealthy man. She said, ' I was furious. I wanted to slap her face. I couldn't stand the looks of her. I know why I didn't like her; she was so smug, so self-satisfied, so pleased with herself—like the cat who had all the cream, licking her chops. She looked as delighted as though she had swallowed the whole world—maybe she did, because the world does not exist for her; nothing exists for her but the good feeling she has for herself. She did not even notice me. I don't think she even knows that I exist. She doesn't need me; she doesn't need anyone. She made me feel so small, so insignificant. I felt like an outsider, so dissatisfied with myself. What a contrast between her and me! I am never satisfied; I am always hungry. It makes me think of the time when I was in my bedroom sulking while my mother was in the kitchen, busy feeding my younger sister. I was so furious, so envious.' (This memory consistently reappeared in the analysis in association with oral envy and rage over oral deprivation. The incident referred to had taken place when the patient was a little over 4 years of age, at a time when she combined her resentment at oral deprivation with her penis envy, blaming the frustrating mother for both.) The patient's associations then continued, ' It makes me think of the time when I first saw my mother and sister in the bed after my mother returned home from the hospital. How unhappy I felt when I saw my sister sleeping so quietly next to my mother, so peaceful, so at rest. I wanted to get into bed next to my mother and push my sister out. I was so hungry for my mother's love. That is the picture that always comes back to me at times like this.'

It is clear from this material that the patient's reaction to the smug person is based upon a very intense feeling of envy. The calm, self-satisfied repose of the smug person represented the fulfilment of the patient's own wishes, namely, to achieve the tension-free sense of satiety and to fall asleep at the mother's breast. The smug object of her hostility was unconsciously identified with the well-fed younger sister, satisfied and self-satisfied, now blissfully withdrawn into sleep after having nursed her fill at the mother's breast. The sense of withdrawal of cathexis from the external world is reflected in the patient's statement that for the smug person the world does not exist because she has swallowed it (2). To the patient, furthermore, the smug person represents a usurper, a younger sibling who has stolen her rightful place at the mother's breast. The outraged sense of injustice which the smug person stimulates is associated also with the need to inhibit the wish to push aside the usurping rival. This attitude becomes more explicit in the next case presentation.

Case 2:

Dr. K., a 43-year-old physician, suffering from a character neurosis, was chronically depressed, inhibited, and pessimistic. Since any emotional display was most unusual with him, it was all the more striking when he responded with violent rage to an encounter with a colleague whom he considered smug.

The patient's passive oral wishes had a complicated structure stemming from both pre-oedipal and oedipal conflicts. The father was ineffectual and rather unsuccessful, while the mother was an

active capable professional woman, apparently with a good deal of musical and artistic talent. To the patient the mother unconsciously represented a phallic woman, and in some of his fantasies intercourse between the parents consisted of the mother nursing the father as she had the younger sister.

An especially intense castration anxiety had regressively reactivated and accentuated oral conflicts, but for other reasons such material would inevitably have dominated the patient's productions. In the first place he had come to me after a number of years of what he considered an unsuccessful analysis with a woman therapist. Actually one of the patient's goals in treatment, which in his mind was associated with economic security, was beyond his therapist's capacity to fulfil. Secondly, during his course of treatment with me his mother was dying of cancer of the breast. Because he had administered a course of hormone injections to her some years before for menopausal symptoms the patient kept reproaching himself with the thought that in some way he was responsible for his mother's developing cancer.

After having been breast-fed for a year he had been weaned suddenly and precipitously in order that his mother might enter upon her professional studies. A devoted grandmother took care of him, but his reaction to weaning was, nevertheless, most severe. He lost his appetite, became constipated, would not sleep, and cried so piteously and so continuously that the distraught grandmother permitted him to suck at her dry breasts in order to quiet him. The patient thus had what Abraham characterizes as a ' primal depression ' (3). No sooner had the mother completed her professional studies than a younger sister was born. The mother was particularly attached to this younger sister for several reasons, one being that this sister suffered from an hereditary form of deafness transmitted to her by the mother. The patient's lifelong complaint had been that his sister got everything and he got nothing. As he put it, ' No red carpet was ever rolled out for me. I always had to get in through the back door.' At a relatively late age he married a girl who was more or less picked for him by his mother, and whom he knew to have prospects of inheriting money from her parents. Towards his own two children the patient was extremely overprotective, living in constant dread lest they would fall out of the window. Professionally he was convinced that he would never succeed, and that with the first worsening of the economic situation he would lose his patients and have to face the danger of starvation.

The reaction to the smug colleague came about in the following way. During a period when the patient was feeling more than his usual concern about not having enough patients he felt that a colleague, Dr. X, was influencing the relatives of one of his patients to withdraw the patient from treatment with Dr. K. In reporting this incident my patient became very furious, but did not think of doing anything about the situation. I pointed this out to him and suggested that he could get in touch with Dr. X in order to ascertain the true nature of his interest in this case. On the following day he returned and reported a fantasy which he said had filled him with a very positive feeling of satisfaction. He felt that both he and Dr. X were in analysis with me and that I was taking his part. ' For a change ', he said, ' somebody is on my side against a greedy, grasping rival instead of the way it has always been —vice versa.' He then added, ' I have known Dr. X for some time. I cannot stand him because he is so smug.' In explanation of this remark the patient stated, ' He is selfish, egocentric, self-satisfied, greedy, and grasping. He never feels guilty; he doesn't consider that he does anything wrong. He is a snob. He makes you feel inferior and frustrated. He is like all smug people. You cannot influence them; you cannot teach them. They are close-minded. They are not gentle. It reminds me of another one of my colleagues who asked me what kind of music I liked. When I said I liked Dvořák he looked down his nose at me. He is the kind that likes fourteenth-century music played on obsolete instruments.'

The patient went on to say, ' Smugness is a disease. I never allow myself to be satisfied. There is a danger in being smug. I didn't show off my medals and decorations. I don't have an attitude of " Pull open your jacket and show off your fat belly with your Phi Beta Kappa key," but Dr. X is that way. He beat me to several jobs. He is the fair-haired boy and now he is sitting pretty. He has plenty of patients and he is eating off the fat of the land. When we were in the Navy we both took a course at the same hospital. He walked in and smugly displayed his service coat with the " fruit salad " (military slang for campaign ribbons) on it. Whenever there was a job open and we both tried for it he beat me to it. He got my place. I can't tilt at windmills. He has everything; I have nothing.'

The use of oral images, ' fat belly ', ' fruit salad ', ' living off the fat of the land ', was pointed out to the patient. In response he stated, ' Yes, he reminds me of a stuffed fat baby drifting off to sleep. That is why you can't teach smug people anything. They are asleep but they don't know it—which reminds me: I got up early this morning; I could not sleep; something is wrong, I don't feel anxious, but . . . I'm always dissatisfied. I set goals high and I never reach them.'

The patient's associations then turned to gifts. A rich cousin of his had just had his home decorated most expensively through his father's generosity. This cousin as a boy had had hundreds of dollars worth of electric trains and track. The patient complained that his son had only a very small set of trains. An uncle in Florida gives his son thousands of dollars a year in gifts in order to avoid inheritance taxes. Now he gives gifts to his adopted grand-

children. The patient reported that he had had the thought, ' Why give the money to strangers or the government? Why not give it to his nephews or nieces? I wonder . . . am I in his will? ' He began to berate his father-in-law for being so generous in his charitable contributions. He attacked professional solicitors for charity as racketeers who pocket the money for themselves. He gives to charity reluctantly, he said, because ' everyone takes from me, but who takes care of me? ' He then recalled that his mother had recently received two beautiful ash trays as gifts and that he had had the thought that when she died she would leave these ash trays to his sister and not to him. Suddenly he checked himself and asked, ' Why all this talk about my hunger for gifts and what I want from my mother? Good heavens! ' he exclaimed, ' to-day is my sister's birthday.'

Only with great reluctance did thoughts of his sister's birthday find expression. If she had never been born he would have had everything. He had sent her a birthday gift grudgingly. When he gave her husband a bottle of ' Black Label Schenley ' he had the thought, ' Poison has a black label on it, too.' He added, ' This week I have been more liberal in prescribing drugs for my patients. I used to be afraid of prescribing drugs for fear of poisoning someone. I was also afraid that some patient would have an idiosyncrasy to a drug and die. Even aspirin would frighten me; the patient might develop tinnitus and deafness. My sister is deaf.'

Subsequent associations referred to his earliest recollection of his sister when she first came home from the hospital. He had to be quiet in order not to awaken the new baby. Upon seeing his mother nurse his sister he had apparently tried to suck her breast because he recalled an incident—obviously a screen memory—in which his mother's breast had been pumped of milk, the milk placed in a ' gravy boat ' with a long spout from which he then proceeded to suck. He did not like the taste of the milk and as he spat it out his mother laughed at him. (It was indeed with the analysis of his reaction to smug people that the dramatic information about sucking his grandmother's dry breasts and other material relating to cannibalistic fantasies were first obtained.) He complained at the injustice of the favoured treatment which his sister had received, comparing her again with the smug Dr. X. Both were greedy, grasping, sated, and untroubled by feelings of guilt. He felt himself to be dissatisfied, hungry, and conscience-stricken.

To summarize the material: The fantasy that both he and Dr. X were in analysis with me and that I was favouring him and protecting his economic security was a wish-fulfilling transference fantasy marking the date of his sister's birth. I represented the mother, and the smug Dr. X was identified with his newborn younger sister. In the fantasy, however, the relationship is reversed. The patient is the favoured one, receiving the gifts. He is the newborn child, happily asleep at the mother's breast. Since hunger and frustration are necessary concomitants of wakefulness, object-finding, and learning, it is clear why the smug person, identified as he is with the sated, sleeping nursling, is characterized as close-minded, unteachable, and not amenable to influence.

In this material, furthermore, the patient identifies the pangs of conscience with the pangs of hunger. For the smug person there is no tension between the ego and the superego, a state which may be compared with a sense of fusion between the sated nursling and his object. The loss of self-esteem which accompanies feelings of guilt may be genetically related to the sense of helplessness of the ' abandoned ' child. Thus the inwardly perceived effects of the superego, which in certain respects behaves like an internal persecutor, may have as their prototype not only the unpleasant sensations stimulated by the faecal mass (4, 5, 6) but also the painful affects of hunger. One cannot feel smug and guilty at the same time.

The relationship between satiety, sleep, and smugness was explicitly stated by a young male patient, a ' borderline ' case with severe oral conflicts characterized by insomnia, alcoholism, and sexual promiscuity. He was most intolerant of smug people, going out of his way wherever possible to upset their composure and to irritate them. One evening he discovered that his mother, a barbiturate and alcohol addict, had stolen from his cabinet a bottle of liquor which he prized. He became furious with her and, in recounting his reaction during the analytic session on the following day, said, ' I asked her if the liquor were mine, where she got it, why was she drunk. My words did not disturb her. She did not even hear me. She had that glassy stare, that smug, unseeing look of the self-satisfied drunk. This I could not stand. I began to scold her, shouted at her at the top of my lungs—no effect. She was asleep with her eyes open. This made me even more furious. " I will wake her up," I said, " even if I have to slap her face." I remember now where I saw that look before. It was on the face of a fellow who went to military school with me. I used to get food from home which I would save in a strong-box. Once I found that the strong-box had been forced open and the roast turkey which I had hidden was gone. I knew who had eaten it; I went after him and found him on the drill field. He looked so smug and so smart. He did not even notice me. I hauled off to sock him and I would have killed him if the gang hadn't stopped me.' The patient used to save his food in order to eat alone in a secret cave which he had found in the meadows near the boarding school. This solitary play represented an acting out of an intra-uterine fantasy which appealed to the patient who had enjoyed the special status of an only child until the age of eight when he was enrolled in the boarding school and was suddenly confronted with a multitude of boarding-school

siblings. Following Lewin's (7) idea about the relationship between satiety and sleep we may speculate that the state of self-contained smugness corresponds to a waking representation of sleep in which cathexes are practically completely withdrawn from the external world and reinvested in the subject's own self representations.

It is an inevitable experience for the analyst, in the course of therapy, to be accused sooner or later of being smug and complacent. Such an accusation comes rather characteristically from women with intense penis envy and strong oral dispositions. In the transference relationship of several patients of this type the analyst was identified with the evil mother, charged with depriving the little girl and frustrating her oral needs, a factor which Freud emphasized in his later studies of female sexuality. The smug possessor of the phallus is equated with the favoured child who has been generously and appropriately fed. Feelings of this kind not unusually emerge at the time of the menses. In the course of one session during her period a patient attacked the following individuals in turn for their smugness: the analyst, her husband, a very masculine girl friend who was an excellent athlete and much too fat, and a former patient who had completed her treatment and was now contentedly pregnant.

The patient had been weaned early because, at the age of four months, she had developed colic, food allergy, and eczema. It was many months before this condition could be brought under control. During this time she became sleepless and hungry and cried a great deal. In addition, in order to prevent scratching, her hands had been pinned to the bedclothes. These feelings of deprivation were combined with her hostility towards her mother during the phase of penis envy. She had wanted to have curly hair like her brother. Her mother had told her that if she ate lots of raw carrots the desired transformation would come about. She followed her mother's advice faithfully only to come to ultimate and bitter disappointment. In this patient's thinking the brother, the husband, the analyst, the woman athlete, and the former patient were all smug because they had a penis which they had acquired through being properly cared for and fed. She equated being castrated with being hungry, sleepless, and dissatisfied. On the other hand, being phallic and pregnant were the same as being sated, asleep, and smug. The self-contentment of pregnant women, incidentally, is, perhaps, the one situation in which the term ' smug ' is used with a minimal sense of opprobrium. The relationship of the self-satisfied repose of the pregnant woman to fantasies of an oral nature is too well known to be expanded upon at this point. A necessary precondition for the enjoyment of this state by the pregnant woman is freedom from guilt over the oral fantasies involved. The investment of the superego with oral sadistic drives is the link which connects the sense of painful self-judgement with the feeling of hunger.

Up to this point the material has been drawn almost exclusively from the violent reactions of envious patients to smug persons. How accurately does this model as projected by these patients reflect the mental state of smug people? It is difficult to answer this question because genuinely smug people, if such exist, do not as a rule come for analysis. There are, however, a number of situations which afford at least a partial or suggestive answer to this problem. To begin with, the state of being smug is only a temporary frame of mind usually evoked in a very definite context and serving various intrapsychic purposes as a result of a complicated genetic development. Occasionally patients do report experiences in which they felt smug or in which other people considered them so. It will also be recalled that earlier in this paper a number of the patients who reacted with such intensity to smug people were themselves accused on several occasions of being equally offensive in the same fashion.

The type of smugness which patients most often are prepared to ascribe to themselves is the sense of self-righteous complacency felt at the débâcle of some unfair, greedy, grasping competitor. The spectacle of fate punishing the guilty not only justified their own renunciations but was accompanied by a feeling of elevation of self-esteem from a sense of superego approval. A professional man reported that he felt smug on reading in the newspapers that two of his professional rivals had been apprehended perpetrating some illegal transactions. He stated that he disliked them both because they were smug. ' Now that they are in trouble, I can almost feel smug. I don't like smug people. They are selfish, grasping, without the gnawing sense of guilt. They do not realize their potential. They do not help others. They get their success the easy way.' One of the professional rivals was described as being condescending towards the patient; ' He has had more than his share of success. He got it illegally. I used to get furious if anyone were condescending towards me. For example, X was smug and very condescending towards me. He pushed me out of my position in the office. He studied my records and methods in order to supplant me.' Further associations indicated that these two dishonest professional rivals had been considered the ' white-headed boys '. Before a younger sister had been born the patient stated that he had been the white-headed boy. Subsequent associations revolved about the theme of sibling rivalry, nightmares which followed the birth of the younger sister and various methods which the patient had used to torture the young usurper.

Certain aspects of the mood of smugness resemble a quiet form of elation. This mood of quiet elation, this diminution of tension between ego and superego is often conceived of in terms of oral rewards. For elucidation of the oral component of elation we are

indebted to the observations of Lewin (8). Similar observations on the feeling of triumph were made by Fenichel (9) and Helene Deutsch (10). The woman patient mentioned above who had been told that her hair would grow curly like her brother's if she ate carrots demonstrated this connexion between smugness and triumph. After having got the better of a male competitor she reported that she felt very smug, no longer hungry or dissatisfied with herself, quietly complacent ' like the cat that ate the canary '. Because of her strong oral fixation almost every success which this patient experienced was felt in terms of oral gratification.

A coldly aloof, self-satisfied air of complacency may be used in a hostile and defensive fashion to humiliate competitors and to demonstrate one's invulnerability, indifference, and independence from potential love objects who have the power to rebuff, reject or humiliate. Such smugness imparts the hostile connotation ' I do not need anyone; anything I need I can find in myself.' The hostility intended by this type of smugness may not be conscious, but the attitude of being a completely self-satisfying and emotionally self-contained unit usually is. Such an assumed air of smugness often serves as a defence against painful feelings of social anxiety and inferiority in narcissistic patients. Two such patients had affected this pose by consciously exploiting what Olden (11) has called ' the fascinating effect of the narcissistic personality '. For the reasons already elucidated earlier in this paper they both despised and were extremely irritated by smug people. To one of these patients, nevertheless, it came as a shocking surprise that she had created the impression of smugness on several occasions when she actually was aware only of defensively withdrawing into herself because of her own anxiety. During such times this patient, the first one reported on in this paper, would become extremely hostile to her unresponsive and threatening environment and would entertain the fantasy that she was indeed the invulnerable and independent figure of a Greek goddess, the ideal to which she aspired. The second patient, an attractive model whose system of security was being undermined by her fading beauty, was constantly aware of the impression which she was creating and of the method which she used to create this impression. She was an ' as if ' personality (12) who was completely dependent upon her environment for her own sense of self-esteem. When she entered a new social situation which she felt she could not master she knew that by standing off alone in some prominent position and acting like one aloof, distant, and self-absorbed she would inevitably arouse the interest and attention of a number of people. When such attention was not immediately forthcoming and the patient felt herself growing anxious she would imagine that she had a very long, full breast which she could put into her own mouth and suck. In this manner she could become completely and happily detached from the unresponsive or unfriendly environment, and it was at such times that she imparted the impression of her smugness to observers. Another version of this fantasy of being a completely self-contained emotional unit appeared in a dream in which the patient saw her house tenanted by all the outstanding figures in the artistic, theatrical, literary, and entertainment worlds. While it is undoubtedly true that this type of smugness is the end-result of a complicated genetic development in which an air of hostile repudiation of dependence on the environment is outstanding, it nevertheless remains a fact that the capacity of such individuals to inflict pain on those who observe them through an assumed air of smugness is related to the narcissistic mortification which they thus inflict upon their observers and by the sense of envy which an air of self-containment is capable of arousing in most people.

Support for these conjectures comes from a recent study by L. Rangell (13) on the subject of ' Poise '. From clinical, neurological, and biological considerations he emphasized the rôle of the mouth and the peri-oral areas in clinging, supporting manoeuvres for the purpose of maintaining narcissistic and other forms of equilibrium. One of his patients, for example, could maintain or regain her social poise through the reassuring presence in her hand of a cocktail glass.

A comment on object relations and narcissism is pertinent at this point. The narcissistic type of object choice characterized almost all the patients reported on. Several of them were attracted only to smug people as love objects. A. Reich (14) has shown how the regressive reinstitution of this type of object choice may be used especially by women with problems of penis envy to fend off feelings of narcissistic mortification. The choice of object follows the prototype of the archaic infantile ego ideal, usually an omnipotent parental figure. While mortification at the advent of and the loss of love to a younger sibling were pre-eminent in this material, other forms of narcissistic mortification, viz., penis envy, frustrated oedipal wishes, etc., serve to reinstitute in a regressive fashion a fantasy of securing invulnerability from disappointment and humiliation through identification with the sated nursling. The material presented suggests that the model of omnipotence may be derived from the invulnerability to stimuli or to narcissistic mortification which the young child imagines to be the happy state of the sated, sleeping nursling.

Conclusion

Those who have known severe hunger and its later representations, i.e., absence of narcissistic supplies, most bitterly resent smug people. They find it most unjust that others should enjoy what they have had to renounce and can no longer experience. The ideal prototype of the

smug individual is fantasied as the well-fed nursling falling asleep at its mother's breast. Smugness represents oral satiety with incorporation of the good object. The object may be represented in current experience by fame, success, etc., but it is ultimately identified with the penis-breast and milk. Smugness implies a temporary diminution of tension between ego and superego plus a relatively large and transitory withdrawal of the cathexis invested in objects. The freedom from tension and withdrawal of object cathexis correspond to the state of affairs which may be assumed to hold for the infant happily asleep after feeding. In this respect, smugness is in the nature of a waking representation of sleep. (It probably differs from mania in the easy reversibility of the process of cathexis of self-representations back to cathexis of object representations.) The various attributes ascribed to the smug person—his self-satisfaction, self-absorption, lack of awareness of the environment, the pleased look on his face and lips, the absence of guilt, his greediness and grasping, and his inability to learn—are derived from this situation. Hunger is the awakener, the source of frustration which directs the individual once again to the world of objects where the process of learning can develop. Guilt over oral greed interferes with the ability to be smug. Some negative reaction to smugness is present to some degree in everyone—to the extent that all human beings in some measure yearn for the tension-free sleep they enjoyed in their mothers' arms. It is an early and undoubtedly basic narcissistic mortification that the individual must awaken and know hunger while others seem to sleep their lives away in blissful satisfaction.

NOTES AND BIBLIOGRAPHY

1. Presented in part at the Midwinter Meeting of the American Psychoanalytic Association in New York, 4 December, 1954. I am indebted to Dr. Annie Reich for her criticisms indicating points which needed clarification.

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TRAUMATIC ELEMENTS IN THE ANALYSIS OF A BORDERLINE CASE[1]

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Before going into the details of the case here considered, a few notes on trauma which can be kept in mind during the description will be useful. Although this presentation is primarily clinical, it will also be useful to provide at least a skeleton theoretical framework in which the traumatic neurosis can be placed.

Ordinarily the psychic apparatus maintains an equilibrium between external stimuli, tension within the organism, and discharge. When the influx of stimuli is so great and so rapid that it cannot be assimilated, we call the resulting condition a traumatic neurosis; when the discharge is severely blocked, we call it a psychoneurosis (4). We understand that these are relative concepts and that there is an inverse relationship between the quantity of stimulus and the amount of blockage necessary to precipitate a neurosis. What happens to the excess stimuli that cannot be assimilated? Freud (6) began the answer to this question and has done the basic work in such studies. His original observations on the method of mastering traumatic stimuli by repetition are fundamental. The change from passively experiencing stimuli to actively repeating them is an important step in mastering them. This occurs not just in those major events which we call traumatic situations, but in many minor crises occurring constantly in daily life, the trauma of which is often mastered by prior rehearsal and subsequent repetition. As we know, Freud went on from this mechanism of handling traumata to develop it into the principle of the repetition-compulsion which overrules or displaces the pleasure principle. Thus he finally evolved his concept of the death instinct; but here we are concerned only with the question of mastering intense stimuli.

With a sudden overwhelming stimulus the 'protective stimulus barrier' is destroyed, leaving the ego flooded with excitement which it is helpless to handle (3). The healthiest and most economic method, other than appropriate discharge, is by a binding of the stimuli, and thus their neutralization. This, however, necessitates a change from the primary to the secondary process, which means that the ego must be sufficiently strong and highly developed to have this capacity to bind. It goes without saying, therefore, that traumata very early in life cannot be handled in this way. An early method is denial, in which stimuli are considered non-existent (5). This is a normal protective mechanism in earliest infancy, but if it persists, it results in a break from reality and becomes a mechanism of psychosis. The organism, in order to protect itself, may have to utilize inhibition of function, which after formation of the ego may be a general inhibition of ego functions, such as fainting, or more focal, such as inhibitions of movement, sight, or hearing. It may also remove itself as much as is feasible from contact with any stimuli. Regression, another primitive adaptive mechanism, is used when the weak or immature ego is confronted with excessive stimuli. Frequently, as a result, active methods of coping with reality are abandoned and oral receptive methods substituted. There may be an even deeper regression to an early narcissistic state. Where the stimuli also are too powerful for somatic discharge, the excess may be deflected internally into the vegetative nervous system.

Denial, regression, inhibition, and internal discharge are archaic methods of handling excessive stimuli, either external or internal. They are mechanisms based on the biological and physiological equipment of the infant, and are concerned with excitation and inhibition in the reflex pathways (17).

In psychoneuroses stimuli defended against are instinctual in type, having become dangerous by virtue of previous traumata, threats, and prohibitions. In the earliest phases instinctual stimuli may be handled by reversal into their

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opposite, turning around on the self, projection and introjection as predominant mechanisms, but as the ego matures and strengthens, reaction formation, repression, conversion, character change, and sublimation become possible. With blockage of discharge a surge of instinct may become traumatic. The sudden withdrawal of the means of discharge, such as loss of an object, may also increase the level of tension to a traumatic degree. Glover (12, 14) has presented an essentially similar description of the function and development of the psychic apparatus.

In some respects, the position of repetition in the mastery of traumatic stimuli is unique. It is a primitive method, and we can observe the biological substratum in the reflex removal of irritants in the spinal frog, in the scratch reflex of animals, and in the various riddance reflexes; processes which may continue until success is attained or exhaustion supervenes. The maturing ego can, however, make active use of this method, resulting in highly organized behaviour patterns. It is an emergency discharge mechanism at any period of life, and is effective, in that it can discharge large quantities of energy, and is therefore of considerable economic value. Traumatic stimuli which cannot be assimilated by other methods become subject to mastery by repetition. If other appropriate mechanisms can be used when the emergency subsides, the repetitive method may be eliminated. Glover (13) has called this mechanism the first attempt of the organism at ' autoplastic psychotherapy '. He adds that ' unlike regression it seeks to master, not escape from dammed up energies '. There is a factor which may prevent elimination of the repetitive mechanism. The ego, by inhibitions such as denial and repression, may exclude part of itself in order to prevent the rest from being flooded with excitement. The biological substratum of this mechanism would be autonomy. With the continuing influx of both external and internal stimuli into this walled-off portion, the increase in tension would be expressed, sometimes explosively, without participation or control from the ego, in repetitions of fantasy, thought, and action; but we should distinguish between psychoneurotic repetitions in which a repressed tendency again and again seeks gratification and is each time prevented by defensive measures. This is a repetitive search for gratification which the superego and ego forbid, and must be differentiated from repetitions with the purpose of mastering intense traumatic experiences. Traumatic stress, whether of a libidinal or aggressive nature, is handled by similar techniques, and it may often be observed that a single repetitive act will involve both instinctual elements.

I would like to remind you also of the clinical features of traumatic neuroses (16, 18, 20, 22):

1. There is fixation on the trauma although repression or denial is the rule.
2. Constriction of the ego with varying degrees of inhibition of ego functions.
3. Regression.
4. Autonomic discharges, episodes of anxiety and rage, and sometimes convulsions. These may be repetitive and be specifically determined by incidents of the trauma.
5. Dreams of a stereotyped perseverative kind which attempt to abreact and master the trauma. The dreams may mirror faithfully the original precipitating situation, and in our experiences in World War II we often noted that the dreams repeated each other, detail for detail. My material illustrates and confirms much that Ella Sharpe states in her book on dream analysis (21). She says, among other things, that unaltered dreams indicate actual events and definite experiences; that repetition in dreams and associations are the best evidence of actual experiences, and that much affect indicates a memory of a real event. My material demonstrates that many elements in the manifest content can be traced not only to reality factors but to the most meaningful and traumatic episodes.

Report of Case

Ann, a 45-year-old anaesthesiologist, entered treatment three years ago because of attacks of peptic ulcer for the preceding ten years. Her internist advised psychiatric therapy in addition to medical treatment. Her complaints on admission, in addition to the ulcer, were the strain in her work, poor relations with her superiors, her hatred towards her family, and her sensitivity to being unmarried. Not mentioned as a complaint was her frigidity. About 5′ 4″ in height, she is neat and trim in appearance, rather angular, dark-haired, walks firmly and purposively. Speech was brisk and clipped and words were not wasted.

The cast of characters in her story consists of the parents and eight siblings, five of whom survive:

Gwen, the mother, at first described as a warm, loving maternal person, later as a cold, harsh, physically weak, masochistic one, died at age 30 after giving birth to twins.

Honest John, the father, rigid, strict, occasionally

pleasant, often furious, full of self-sacrifice; never remarried because of faithfulness to the memory of his wife; admired by everyone, especially himself.

Bill, an older brother, eight years Ann's senior, tall, dark, and handsome; man-of-the-world type and a little psychopathic in early adulthood; left home, aged 25, after a bitter quarrel with his father; bought a new name for $25 and became a seafarer.

Clara, an older sister, kind, motherly, but deserted the 13-year-old Ann.

Helen, another sister, pretty, popular, efficient; deserted the 15-year-old Ann.

Allan, another brother, two years older, football hero, also a seafarer, brooding, unpredictable; has an aura of unhappiness and suppressed violence.

Dora, five years younger than Ann, married just before Ann entered treatment; passive, neurotic, kindly.

Ellen, Dora's baby, now about three.

These are the living siblings, but more important perhaps have been the ones who died:

Flora, born when Ann was two, died when Ann was 3½ of pneumonia after an accident in a flood.

Twins, one with a head injury; died two weeks after birth.

A view of the patient's life with the major events recorded will help to give a background structure on which the dynamics can be observed. The patient was born in a poor section of an Eastern American town where floods were frequent. At the age of five, a few months before her mother's death, sex incidents occurred in which a man 25 years of age put his penis between her legs from behind. She would threaten to stop co-operation unless given a nickel. This, at first, was all that she could recall. She spent her childhood from 5 to 13 in an orphanage in a town in another section of the State. She received occasional letters from Bill, a few gifts and two visits from her father. In her early description, her life here was quite uneventful and she called it the happiest period of her life. Most remarkable was almost complete amnesia for any event during this time, and there was no feeling of the atmosphere of the place until much later. It then became to her a 'dreamy' and 'zombie' type of existence. However, she took an active part in games, was quite athletic, and excelled in several sports. Menarche began at the age of 12, and a year later Bill came to take her home to start the new phase of her life.

Prior to analysis she had looked on her adolescence as the most unhappy period of her life. Analysis succeeded in showing her still more unhappy periods. She gained tremendously in weight, reaching 190 pounds. She avoided men and men avoided her, and she had no dates at all. She felt, and indeed was, quite unattractive. She had contact, and then only in a superficial way, with just two girl friends. One by one, the rest of the family left home. Clara and Helen were married. Bill left under a cloud after having embezzled some money, together with his uncle, who was sentenced to gaol. Allan left for college. Dora, the patient, and the father remained. By this time the family had moved to another house and the father had acquired a small neighbourhood store in a slum area. Here the patient helped out at the store and, after her sisters left, took over the responsibility of the household, as well as its drudgery. She finished high school at the age of 16 and remained at home until the age of 18, when she left for her pre-medical work. At this time she left the dirt, squalor and misery to Dora, as well as the father's love.

She lost her excess weight and began tentatively to go out with boys, although she was very much frightened. Her first sexual affair, entered into very deliberately so that she could control the excitement, occurred at the age of 22. On completion of her medical training she became an interne in the hospital in which her mother had died. During this period there were no outstanding events and she had only a few desultory affairs. She visited her sisters occasionally, and on one occasion when she was 28 her father was seriously injured in a car accident and finally died in hospital. The patient transported his body to the burial plot in her home town, and on the train, on a sudden urge, she invited and had a sexual experience with a stranger.

At the age of 32 she went into the Army, remaining there for five years. She found adjusting to authority unbearable, and it was during this time that she had a tempestuous affair with George. She was so close to having an orgasm at this time that she forswore intercourse entirely, and has had none since that time. Her ulcer, subsequently dated to age 19, became severe at this period, and she had intermittent attacks of great severity. Most of the clinical features of her neurosis began during this time. Depressed and miserable following her discharge from the Army, she went to a large eastern centre to study photography, an early interest of her father's. She soon gave this up and at the age of 39 she became an anaesthesiologist in a large hospital. She felt that the authoritarian *régime* of the Army was continued in this hospital, and her symptoms became progressively worse. She developed a very severe ulcer attack, and this finally, with a fear of malignancy, culminated in psycho-analytic treatment.

Psychotherapy with limited goals was the first intention. There was truly a massive amnesia for the first 13 years of her life, which seemed ominous, as well as an early and intense transference hatred. Furthermore, the sudden breaking off of treatment after four hours to visit her brother Bill for a period of six weeks suggested acting-out possibilities which might make treatment precarious. The patient was seen several times weekly at first, and gradually went into psycho-analytic therapy not so much as a preconceived plan but because the exigencies of the situation demanded it. Actually the ulcer pains were relieved in a few months, but pathological

character traits became more prominent and ego-dystonic, and myriads of new symptoms appeared. Furthermore, the development of a working transference relationship indicated the capacity for object relationship. When we had analysed some of her resistances to accepting more hours she came four times weekly and has continued this to date. She has had about 575 hours of treatment.

The patient's life was remarkably empty. It took her 2½ hours to get to her work and back, necessitating her getting up at 4.30 in the morning. Following her characteristically frugal evening meal, she would read for a while and go to sleep early in order to get up early. Her very few friends she saw rarely, without warmth or enthusiasm. An occasional play or concert and rare visits to her two sisters living in the city comprised her social life. There was infrequent correspondence with ' the family '. Her work was the most important thing in her life. Intensely serious about this, she had an excellent reputation among the nurses, doctors, and patients. When not under special tension she would carry on bantering conversations with the operating room team. This, however, could change in a moment and the patient could become bitter, sarcastic, hostile, and crushing. The others, including the doctors, were all rather afraid of her and it was well known that ' Ann always got her way '.

There was a multiplicity of symptoms with new ones or, more accurately, revivals of infantile ones appearing anew as repressions were released. Therefore, only a few of the 67 symptoms and pathological character traits can be described. Driven by her overwhelming fear, there was such a profusion of dreams, fantasies, symptoms, and screen memories that the picture was often chaotic, and appeared at times frankly psychotic. At such times no interpretation was possible, only a repeated reference to her fear. With the development of a satisfactory transference, the fear was sufficiently allayed for her to work productively.

I will now describe the course of the analysis primarily by means of the resistances. In the first few months the patient made desperate attempts to establish an oral dependent relationship with me. Anxiety was intense, approaching panic; she pleaded constantly for medication for her ulcer, the pains from which became extreme. She was very depressed at this time, had thoughts of suicide and threatened it; threatened me with perforation and hemorrhage from her ulcer, and finally threatened to kill me. On one occasion, over a week-end, I was persuaded to give her medication, with the result that her symptoms and acting out disappeared for a couple of days. She gradually settled down as her oral attitudes were interpreted and began to work with considerably less acting out. She then attempted to establish a relationship on an oedipal level, and at this time fantasies and memories relating to the father and, to a lesser degree, to her two brothers appeared. During this phase particularly, a great deal of material relating to the death of the mother in childbirth was brought out, as well as a group of phobic symptoms, which included the following: fears of death; of cancer of the breasts, mouth, gastrointestinal tract and lungs. There were also over-determined fears of psychosis, of sex excitement and orgasm, as well as a group of hysterical conversion symptoms, including a burning sensation in the body, tingling in the legs, and a convulsive feeling with an aura of dizziness. She would smell the odour of orange blossoms with hallucinatory vividness. In response to the oedipal frustration she became hostile, aggressive, and irritable, and acted out transference feelings with people at work; a pronounced example, displacing her hatred to her superior and quitting her job to maintain contact with me. Interpretation of the oedipal desires led to an especially intense penis envy which had contributed to her character traits of jealousy, hostility and aggressiveness and to her masculine characteristics. In her fantasy, each younger sibling in turn was given the penis, but most important was Allan, the closest to her in age, with the physical evidence of this penis. During this phase hostility to me was extreme, and she struggled bitterly to determine who would be castrated and who the castrator. In this she repeated her struggle with George where the issue was: ' who would have the orgasm and be destroyed '. Along with the penis which she fantasied she obtained went the feeling of power and control, a determinant in her profession of anaesthesiologist. Sarcasm and a biting wit were used to frighten me and her fellow workers, a means which, for years, had kept her own family cowed and wary of her. She would try to stop up my interpretations by anger and would tease, insult, and revile me in order to get me angry. She called me ' crazy ', ' careless ', and ' incompetent ', but at the same time was very fearful of me. If I moved in my chair, she would become tense, ready to get up and run. My position behind her was reminiscent of the sexual incident where the penis came from behind. Overtly hostile behaviour alternated with a more covert attitude of dull but vicious boredom, in which stubborn silences were prolonged and frequent. Often her reaction to punishment in the past had been grim silence, like the screen memory of the white-faced girl in the orphanage who was publicly accused and whose guilt was known to all. She could be hard on me since she felt she was my favourite patient and I was so eager to get her well. As we came close to identifying the actual seducer, she defied me to do so and postponed the recognition of memories and attitudes because there was no objective confirmation. At the same time, she assiduously avoided easily accessible information from her older siblings.

She had other defences. She tried to make herself indispensable to me by being a good patient, just as she felt she was indispensable to her father in her adolescence. She quoted poetry and classical

literature to impress me, as she had composed poetry to please her father. At the same time when she was ready for an insight, she would read psycho-analytic books and attribute the insight to her reading rather than to the analytic work.

Interpretation of the penis envy led to the ambivalent relationship to her mother. Thus, the next phase of the analysis was concerned with this area. In the transference I was predominantly the mother figure. Demands for love became urgent, and when this was interpreted, the invariable reaction was depression, suicidal preoccupation, and finally hostility. Intense oral desires were apparent, and it became obvious that she had little real object relationship except in terms of devouring or being devoured, along with defences against this. She needed people for praise and for relief of guilt. It was only with the working through of these oral factors that she could establish any relationship with her fellow workers and sisters and at last ' have some friends '. She began to realize her intense greediness, and the reaction formation to this in which she became a spendthrift character. This also served her masochistic needs. On several occasions, under the influence of her guilt feelings, she abstained from masturbation, and did so by identifying me with her disapproving mother. It was during this phase that marked regressive phenomena appeared with some of the key memories, including details of the sex incident, early sex play, hints of the primal scene, and the recollection of Flora's death.

The patient had a rigid attitude on the couch, sometimes with hands crossed on her chest. This had several determinants, one of which was an identification with her dead mother. Another was the complete inhibition of seductiveness with the fear that any free movement would be interpreted as seductive. She handled this unconscious desire to be seductive partly by projection, resulting in the conviction that I would try to seduce her. It was only with interpretations of this and the recollection of the precipitating events that she could permit any expression of these feelings. Other inhibitions also appeared, such as the avoidance of being well dressed and of being in a bright light. She avoided excitement such as surprises, even to surprising others by arranging her own birthday party.

During this phase of the analysis one of the most important fantasies was elicited. She had a fantasy of being pregnant, a fear that the baby would grow too large, and had an urgent need to terminate the pregnancy lest she be destroyed. This fantasy regressively was an oral impregnation, an intestinal pregnancy and an anal delivery. It resulted in constipation, enemas, and laxatives for twenty-five years. She had frequent cramps and was often confused whether this was uterine or intestinal. Often she would go through the motions of a fantasy birth on the couch. She was afraid that any mounting tension would eventually have to explode, at times in the form of murderous anger, at times as projectile speech, and at times as violent expulsion from the bowels. The interpretation of these factors resulted in a distinct surge of well-being.

Masochism as a resistance was ubiquitous and the most important characterological difficulty. She constantly put me in the position of the accuser, the criticizer, the insulter. She tried to make me give up the treatment to give her a masochistic triumph. Over and over again, she accused me of not helping her, of not caring, of making her feel badly with my interpretations and making her needlessly suffer. Every operative death was interpreted as a blow from fate and resulted in intense depression and self-blame. Sadistic and masochistic acting out occurred to a dangerous degree. She had several close calls in which she almost killed someone and got herself killed. Once she found herself driving on the freeway on the left-hand side of the road and almost killed a motor-cyclist coming from the opposite direction. Sadomasochistic fantasies were prominent during masturbation; for example, as a prostitute and dope addict she would suck the tongues of police agents until they weakened and collapsed. Fantasies and acting out in the area of moral masochism were pervasive. She acted the part of the Clod (from an early school play), the Ugly Duckling, Cinderella, and Christ. She would lend money where return was impossible. She would do the menial tasks at parties, and she would tease until she was punished, scolded, insulted, or even beaten. With consistent interpretation, she began to realize that she was ' wallowing in misery like a pig, enjoying crying and getting satisfaction in depression '. She vigorously defended her innocence against real or imagined blame. The guilt feeling for a long time compelled her to act out and was not consciously experienced. The numerous deaths in the family were important determinants of her guilt, and her mother's death, for example, gave the semblance of reality to the dire effects of hatred. We can clearly see, as partial determinants of her behaviour, the dying, suffering mother in the patient's ego, and the father conceived as cruel and hostile in the superego. A positive feeling to her father appeared as she became aware of her libidinization of guilt.

A very interesting resistance was the manner of talking in the early sessions. She would skip from one topic to another, giving the highlights but not going into details. These to her were peaks and valleys. The peaks were nice, clean, and shining, and the valleys were damp, dark, and dirty; namely, the penis and vagina respectively. This was used as a method of defence and offence, and we shall find that it originated in the inquisition following discovery of the sex incident. She has made frequent use of this in confusing and bewildering friends and family, and has used it to avoid the recognition of guilt feelings both elsewhere and in the analysis. This originated as denial and had the accretion of the phallic significance later. Until this was inter-

preted the patient insisted that she was freely associating.

Appearing intermittently during the course of the analysis were feelings of unreality and depersonalization. Some marked paranoid trends also appeared. She was convinced that a woman was sitting in the closet listening to her while she spoke. She knew I was recording what she said on a dictaphone and the sounds of dialling meant the click of the machine. Periodically she maintained that I loved her. There were also hallucinations, probably of a hypnagogic variety, in which she heard her name called. She was not quite sure whether this was true or not. She was convinced of the validity of Rhine's work on thought transference. Her paranoid symptoms led to fantasies of her mother with a Mona Lisa smile, who, like a Charles Addams character, was driving her to a horrible destruction. When the underlying homosexual feelings were interpreted, she suffered great anxiety and depression.

Towards the latter part of the analysis the patient became rather dramatic. A flood of tears would signal an approaching vacation, a change from her earlier reaction to my absences which were repetitions of her mother's abandonment of her and resulted in intense depression. In her rôle of anaesthetist she became dramatically a Saviour of Life.

Rarely did the patient verbally agree with interpretations. Very frequently there was no immediate reaction and she would often carry on as if she had not even heard them. However, the reaction would come out in dreams the following session and in actions or insight two or three days later.

Narcissism of course was a marked feature of her illness. Her desire for omnipotence was indicated in her need to control, and her haughty and contemptuous attitude. She also projected this omnipotence on to me, and through passive dependent techniques was able to utilize this power for her protection. Thus I became indispensable to her and no substitutes could be accepted. Her feeling of omnipotence was expressed in her being able to 'kill and bring back to life' the patients whom she anaesthetized. This was an additional reason for the death of a patient being such a traumatic blow to her. She played God in the operating room till the surgeons came and then became their most important instrument. Her narcissism was regularly interpreted to her, but the most violent reaction came when she misunderstood my remark that she had 'a need to appear unattractive' to mean that she was unattractive. This was a strange misunderstanding, as if she meant to say: 'I am now ready to work through this problem.' For a full month the patient went through a period of great torment. She was successively, and sometimes simultaneously, furious, silent, despairing, and apathetic. To spite me she again gave herself enemas, masturbated frequently, and sometimes heard me 'laughing at' her. She felt empty, hollow and haggard, and longed for me to touch her. I was cruel and heartless and she was repulsive. She began to spend long periods of time looking at herself in a mirror, especially her hair, repeating over and over: 'You're ugly, ugly, ugly, ugly.' 'Everything,' she said, 'is taken away from me; all I have is my body, and that is full of hate and ugliness.'

And yet, even in the midst of these violent storms, she could tell me indirectly not to break down; not to give her reassurance. Gradually she brought out the unconscious conception of herself underlying the most obvious fantasy of the Ugly Duckling: She was 'perfect, beautiful, had the finest hair, and her magic mirror reassured her that she was Nefertiti, the lovely Queen of the Egyptians.' This was also the image of her mother with whom she had been in a close narcissistic union. She relived at this time the intense affects which her apathy covered following the loss of her mother. With her ego well-nigh shattered by that loss, she had a further blow when she was sent to the orphanage. As she lived through this now, her hatred to me and her father again became intense. She acted out this hatred in her fury with other people, and in the transference by invective, abuse, and throwing an ashtray in my direction.

Finally improvement and resolution of this problem was heralded by a dream, in which she gives up the need for prestige by refusing to marry a neurosurgeon she had known. She then realized she could give up her work in anaesthesia, a new, strange, and wonderful thought to her. She was no longer bound to it. This was another turning-point of the analysis.

It is paradoxical that Ann's cruel and relentless superego condoned a certain humorous quality she had. I can mention here the story she told of the hospital which had music piped into its operation rooms. They were doing a lobotomy one day when it was suddenly realized that the music playing was the *Nutcracker Suite*. On another occasion she pinned to the wall of the operating room two identical anatomical plates of the head of a woman with the caption: 'Which twin has the Toni?' From these jokes came elaborations of fear of psychosis and the theme of the twins.

A word about the dreams of the patient, who was a prolific dreamer. At certain phases of the therapy they were used as a resistance, but this was interpreted as it arose. A great number of the fantasies and memories were elicited from the associations to the dreams. She would sometimes tell dreams over and over to many people. The first two dreams were given in the same session, and are described as follows: 'There was a street with many small houses. They were little dolls' houses. I was on my knees with my head inside and one arm in and one arm out. Also, at the same time I was very small and looking at them. I was enchanted with it.' The other dream showed her with George: 'We

were in a small compound with a high brick wall. His penis was stuck to me. We were standing and I was terrified that I might be seen.' The interpretation of these dreams will be obvious in the subsequent development of the material. The dreams were both numerous and repetitive, and this led to the final decision to discuss the traumatic element in the neurosis.

A word about the crucial part of the analysis, the memories which this patient revived. There were four main traumatic events in her infantile life: the death of her mother when she was 5 years and 9 months old; the sex incidents, the most important of which occurred at the age of 5 years and 3 months, in which she was discovered; the primal scenes, three of which occurred between the ages of 2½ and 5; and the death of her sister, Flora, when Ann was 3½. Some conscious memory was present regarding each one except the primal scene. The memories varied in their credibility to the patient. Many she was able to recall and had a subjective feeling regarding their accuracy. Others were recalled in a more vague way, and still others were merely reconstructed, but were dynamically valid in that they produced emotional changes, changes in the material, acting out, and finally further insight. Many memories were confirmed when she finally began to discuss these things with her siblings, and many received confirmation in the dreams. Innumerable fantasies were interposed between the actual incidents and the final symptoms or behaviour.

The most important and the most traumatic element was the death of the mother, but I will summarize very briefly the patient's relationship with the mother prior to the oedipal period. The birth of two younger sisters, with the presence of the already ensconced favourite, Allan, resulted in an intense jealousy and hatred. Her spitefulness, defiance, and rebellion brought on the mother's frequent anger and despair, and she would threaten the children, especially Ann, with dying. By this time the patient was aware of her lack of a penis and already had made a transition to a desire for a baby. Her masturbation had been corrected in a sarcastic manner. But the conscious feeling was one of love and tenderness from the mother, and the memories which persisted were: mother in a green dress looking lovingly down at her, being held in her mother's arms at the age of 4 when she had an ear infection, and snuggling in her mother's bed. In the early years the father was more pleasant and cheerful. She recalled memories of the dogs they had when she was 3 or 4, whom the father carelessly mistreated, but who loved the father and would jump up on his lap to be petted. This was expressed during the therapy by fantasies of intercourse with male dogs, often on her lap, both from the front and the rear. On one occasion she allowed the landlady's dog to lick her genitals.

At the death of her mother the patient is 5 years and 9 months old. She has not yet started school, but all the other brothers and sisters have, except Dora, who is only one year old. The mother goes into a hospital; Dora goes to an aunt for care; and the patient is taken to the hospital daily by her father. Before the baby is born the patient thinks: now at last she will get the child she wants so desperately and lost before. The mother finally gives birth, has a very difficult labour, suffers a great deal, and the patient sees the misshapen head of one of the twins. She sits or stands quietly in the mother's room and sees and hears everything that goes on. She notices the mother's large breasts. She sees her mother get progressively worse. She hears the nurses, doctors, and visitors make various comments about her mother's condition. Mother is burning up with fever. Mother suffers so much. She sees the nurses remove the bloody rags. The mother vomits and a tube is inserted, and finally the mother requires oxygen, also through a tube. The mother's behaviour becomes strange; she calls out and her speech cannot be understood except for the names of the children. Many things impress the little girl. The room is full of flowers. It is spring and there are marigolds and orange blossoms. And now her mother's life ebbs away, but before the end there is a horrible shaking and gasping. A group gathers round the bed, but she cannot be revived. The patient too goes to the bed, but she cannot help, and only gets in the way. She tries desperately to hear and understand her mother at death, but cannot do so. It is all over now, and the patient goes to the front steps of the hospital and sits down in a frozen state. She does not feel and she does not cry. She notices a gnawing in her stomach, and she begins to gorge herself with food. There is no one to help her, so she puts on a new green dress, just a little awry. She is taken to her mother's funeral. She notes the position of her mother in death, and the coins that are put on the eyes of the dead. She goes through the same thing a week later when the twins, her twins, die. She asks herself over and over again: Is mother really dead? It's easier to believe that nothing has happened, that her mother is away for a while and will come back. Mother will be revived again—and here is the nucleus of her future work in anaesthesia, where people can die and be brought back to life. But she cannot deny the truth entirely, and somewhere in her mind she is aware that her mother died, that she was destroyed by the twins; that she died because of sex, and that her father was responsible. Mother had already warned her of sex and masturbation, and told Ann she would be the death of her; but still she keeps her doubt, and she can never say what her mother died of. She recalls an occurrence which she retroactively placed to the time before her mother's death. She would shout: 'What did your mother die of?' And from Humpty Louie, the tamale vendor, came back the call: 'Hot tamale', and this phrase with its double meaning is her

answer. In her state of apathy the patient does not wish to do anything, especially to see any dead bodies. She is pushed to this. This she must not miss. It is an event that occurs once in a lifetime, like a comet or a coronation.

Already we have the explanation of many phobias, conversion symptoms, fantasies and behaviour, and many of these memories formed the latent content of innumerable dreams. There were very many dreams in which boxes, representing coffins, were the main theme, and we can recall the patient's passion for collecting boxes which had to have something in them. Forty years later she wept bitterly when a plant died because it was too big for the box which contained it.

Two months later Allan and Ann go to the orphanage. Allan has a temper tantrum, but Ann is protected by her frozen state. Only occasionally would she sob into her pillow at the orphanage. She developed preoccupations dealing with the absence of a world or ' How would be the world be without her? ' and she would wonder: ' Where do the birds go in the winter? ', that is, where has mother gone? All through her orphanage life there was some feeling of unreality, and it represented a fantasy and an atonement. She knew she would one day be reunited with the king and queen who were her parents. The freezing was necessary at this time because the patient was overwhelmed with too much stimulation and struggled to block the perception of her mother's death. As we can see, she never recovered.

The patient had wanted her mother's death, and she wanted the twins. Consequent on this there was tremendous guilt which she expiated through the subsequent years. She also wished to retain her mother, and an introjection of her dying, pregnant, masochistic mother occurred, of far-reaching importance. All her life she felt that she would die at an early age and had the feeling she was living on borrowed time. She was not lacking in positive oedipal feelings towards her father. She had fantasies of having Dora as her and her father's child, of her father returning to her in the orphanage, and rescue fantasies of the President, her father, and Allan who became a representative of the father. In the transference she had fantasies of having twins by and for me, of having a child by me and dying immediately after. But the feeling was not just positive. As a killer of this woman, the father became a cruel and sadistic figure, and this formed the basis of the later conviction that men are sexual brutes and given to rape and violence. The patient showed the phenomenon of borrowed guilt; that is, guilt through identification with the father. This gratified her need for punishment and gave her a secondary libidinal gain. In her adolescence Ann consciously wished her father's death. She had the conviction that her mother's death must be expiated by either of the guilty parties, her father or herself. At the time of her father's death she had the thought: ' Now father is dying and I am safe '. But two years later she was again expiating guilt in her anaesthesia, both for her mother and father.

The emotional reaction to the death of the parents reached its climax in one of the most dramatic sessions in my experience. In an hour of great agony for the patient she went through the detailed description of the horrible post-operative death of her chief surgeon, to whom she gave the anaesthetic. It became obvious that she was living through the deaths of her mother and father, and what she noticed was decided many years ago, detail for detail. She cried out in her despair as she noted the flowers, the oxygen by tube, the incoherent speech, and the convulsion before death. At the end of this hour she looked at herself—she had worn a short black dress with a bow at the neck and combed her hair like a little girl.

Ann was brought home from the orphanage by Bill, still in the frozen state, but with an underlying excitement that here she might find the realization of her fantasies, particularly find again her long-lost mother. Again she was cruelly disappointed, since both her older sisters were soon married and left home. Her mother's death was partly re-experienced in her adolescence. Her menstruation and the memory of the bloody rags at the orphanage took her back to the bloody dressings of her mother's illness. Their grocery woman's daughter died in childbirth, again confirming her belief that death must inevitably follow sex. For a brief period on her return she was able to draw a picture of intercourse, but following these events a wave of repression occurred and again she regressed to an oral state and to fantasies of pregnancy through tremendous eating. In her medical training some reparative processes began, and she lost her overweight, although she developed mild ulcer symptoms at that time. The dream of the little houses, recurrent since the age of 8, now becomes clear, as the baby too big for the uterus. The game Ann first played on Memorial Day, about the same age, has a similar meaning: she would bury, and then bring a doll part way out of the ground, over and over. Thus she represented both the birth of a child and the return of her mother, and tried to abreact the trauma.

Let us now reconstruct the second major traumatic incident in her infantile life. Sex play was stimulated by the crowded bathtub, the only one on the block, in which sexes were regularly mixed. In the major sex incident Bill, age 12½, inserted his penis between her legs or rectally, had an erection and some sort of orgasm. Allan, 7 years old, threatened exposure unless he had the same privilege. He was inept and somehow hurt the patient. She recalled the cold, wet, repulsive penis, Bill's soft and seductive voice, and the nickel she was given with which she bought peanuts. Ann, too, had been teasing and seductive and was resentful

and jealous when Bill played with her sisters. This incident went through several stages of screen memories. There was the dentist, whose name happened to be the same as a convicted child rapist, who put his hand on her genitals when she was eight. Behind this was the sex incident, with a neighbour as the seducer. Then she said her grandfather came up the stairs, and that he was the father of the seducer, which meant that her father was the culprit. Along with this thought came tremendous hostility against her father and me which almost wrecked the analysis. Then it was the mother of the seducer who interrupted the sex play, and finally the truth came out with much confirmation in dreams and associations. Bill was the seducer. When her mother discovered the sex play, she collapsed, and her father took over the inquisition. Her father tried to question Ann, but she babbled, jumped from one topic to another, was breathless, and could only repeat that it was Bill's and Allan's fault and that she was forced to do it.

More of the patient's behaviour can now be elucidated: the rigidity in body and movement became a character defence against seductiveness. Jumping from one topic to another became a characteristic method of speech. Bill was linked with her mother, and Allan with her father, and physical qualities and personality enhanced this link. She developed an extensive acting out system in order to keep these people apart. In future years she always found two men she would play off against each other, such as two internes in hospital or two assistants in the operating room. She skilfully inflamed one against the other so that they could not gang up on her. Informing on her brothers also had to be repeated over and over again. She would study a patient's chart prior to operation, find old physical defects and minor difficulties not rechecked. Her demand for clearances, blood studies, and re-examinations would delay operations, angering the senior surgeon who would express his anger to the junior for being remiss in his study. This effectively protected her from the feeling of guilt for having set father against son. She tried to convert the passive experience into an active one in fantasies of herself seducing children. Interpretation and acceptance of the acting out nature of her behaviour led to smooth and friendly relations with the surgeons.

Uncovering of this memory led to understanding of the rigidity, which freed Ann to become seductive to me. Interpretations of this seductiveness then brought recognition that penis envy led to the sexual incident. She would try to urinate like a boy and masturbate as if she had a penis. She wanted a penis from her mother but she also needed one to get her mother's love. This was expressed in her urgent desire for a Jaguar car, the money for which would come from her sister Clara, but she would also take her sister for a ride in it. When this was interpreted, her response was, 'I don't believe you for a minute but I know I won't get that Jaguar.' She knew I would love her if she were only a boy. It was hard for the patient to accept, first that she had no penis, and second that she would not succeed in getting one. Maybe she had a penis inside her somewhere like 'frogs and snails and puppy-dogs' tails.' When all else failed her, the pinna of the ear became a penis to her. Homosexual fantasies and a half-hearted relationship with a homosexual girl began, as well as a contact with an older woman psychologist, an obvious mother figure. The expectation of a penis by mouth was interestingly illustrated in a dream of several young birds with mouths wide open, being fed pieces of dough to which was associated George's penis. Having a penis was the ability to control enuresis and, associated with this, emotion. Urination was equated with ejaculation in the vivid experience of horror and ecstasy in voiding with a full bladder. This was equated with the male orgasm, although at such times she had fantasies of embracing me. As treatment continued, she made attempts to give up the penis. In a humorous way, she attached a raisin lightly with collodion to her arm and asked the junior surgeon, equated with Allan, to remove it. It came off in his hand.

The anal aspect of the sex incident had a prehistory in that the patient received frequent enemas from her mother and frequent rectal temperatures were taken. A fantasy of love from her medical training days was an interne giving her an enema and then putting her to bed.

And now let us turn to the revived memories of the primal scene. This occurred at least three times between the ages of $2\frac{1}{2}$ and 5. From a series of dreams and fantasies, this occurred in daylight or a well-lighted room and the patient was able to see, and to hear the noises. On one occasion she opened the door and looked in; on another occasion she looked through a keyhole. She saw the father handle the mother's genitals, which was followed by coitus. The patient was excited, curious, and frightened. Following the episode of the chief surgeon's death, she revived a clear memory of seeing parental coitus with the mother pregnant and on top. The vagina was seen as the rectum, and she made the interpretation of this scene as a sadomasochistic experience and made an identification with both participants. We can now understand the dreams of the patient joined to George by a penis. This, too, explains the conviction that the baby is destroyed by the father's penis in the mother's body. Sadistic and masochistic fantasies, originating in primal scenes, were fused with similar ones precipitated by the other two traumatic events: the sex incident and the death of her mother. As a result of these observations exhibitionism was thoroughly repressed. She now recalled observations of intercourse in animals which she had repressed until her adult years. She disliked lighted rooms, but from the age of eight masturbated with great satisfaction when thunder and lightning occurred. Numerous

fantasies appeared of children watching parents in intercourse, of exhibitions being put on in brothels, and of herself being observed performing intercourse. She recalled a memory, age 9, of lying on another girl, saying, ' You must struggle '.

The last of the traumatic events concerned Flora, born when the patient was two. Ann had already suffered by the mother's preference for Allan, and there was immediate hatred for this interloper who had stolen from her her meagre share of the mother's pallid love. There are hints of sexual investigations between herself and this sister, and she came to a temporary conclusion that this sister had the penis. A particularly extensive flood occurred when Flora was $1\frac{1}{2}$ years old. Ann, Flora, and their mother were in a boat together, and Flora was either pushed or fell out. This was connected with a screen memory of a child falling or being pushed from a window. Whether the patient actually had a part in Flora's death is uncertain and perhaps even unlikely. What is certain is her terrific sense of guilt, and there is reason to believe that the patient jumped in after her, sustaining an injury to her leg. The screen memory of being in the hospital with a bad injury to the leg helped to control the feeling of guilt. Curiously, she became terribly angry when Clara mistakenly suggested that Flora's death occurred before the patient was born. Ann expiated her guilt for this by various methods. She befriended a cousin with the name Flora in various ways throughout the years. When Dora's girl, Ellen, was born, Ann immediately set her up as the little sister, Flora, and acted in an unusually kind and loving way. This accident contributed its share to the patient's fear of falling, diving, and flying. A long series of dreams involving floods ended up in terror and waking. In one dream she is on a ship and falls overboard. The water is black and deep. She floats in the air and finally ends up in a pleasant shallow swimming pool. In this way she tries to undo the death of Flora. As these interpretations were made, her amnesia gave way and she became extremely depressed. She brought out intense feelings of guilt about Flora, who finally died of pneumonia. Only then could the patient bring out her hatred and resentment against this sister, preceded by a dream in which two nurses began to fight as soon as the head of the department left. After this was interpreted and worked through, the memory of Flora became neutral and the nightmares of floods disappeared.

I must omit much fascinating material dealing with her oral attitudes which gave an oral-sadistic form to the Oedipus complex. The penis envy, too, had its antecedent in envy of the breast. The mechanisms of projection and introjection have already been noted. A curious example of the latter is concerned with the ulcer. As will be recalled, the patient's main obligation was to feed the father and thus placate him. Her sister, Helen, acting as a mother, taught her to cook and was a buffer between herself and her devouring father. She attempted to resolve this by introjecting the father, but as the ulcer he still required feeding, and now with milk. Such hysterical elaborations were quite persistent until analytically interpreted, following which the patient showed clinical improvement. Also most remarkable was the relief of ulcer pains by masturbation (not that I would advise this as a cure for peptic ulcer!). Masturbation to this patient was most importantly an oral process. Fantasies were most frequently of an oral type, and she was several times horrified to discover that she was simultaneously masturbating and sucking her thumb. Repressive attitudes of the parents and traumata of lesser severity in earliest infancy, for example the method of weaning, not described in any detail, were important in paving the way for the devastating effect of the four major traumata.

The patient's course in therapy was one of progressive improvement. Her life, generally, has been much more normal. She has developed good relationships with her co-workers and her relationship with her family is completely reversed. She is now capable of enjoying them as well as their families. She has given up most of her pathological behaviour and fantasies regarding her sisters and mother surrogates, just as she has given up her mother's wedding ring which she returned to Clara. Since she had worked through her attitudes to the long dead Flora, she gets a great deal of pleasure in her niece, Ellen. The need for the analyst's love is not urgent now as it had been before, and therapy is no longer looked upon as a sadistic operation. There is considerable diminution of her guilt and masochism, and she feels ' much cleaner and sweeter ' in the past year. She has experimented with ' giving up mother ' and feels able to terminate the analysis now if this should be necessary, although she recognizes that she has further progress to make. She has achieved some prominence and recognition in her field, which in certain phases of her work also involves an acceptance of the maternal rôle.

Her attitude to deaths of patients has changed radically and has become quite rational. Her defence against seductiveness has been eliminated; she now dresses attractively, is more feminine, free and relaxed in her attitude. Pregenital fantasies have given place to genital ones. Fantasies of intercourse increase, while sadistic fantasies of sexually destroying men have disappeared.

In the anal area considerable progress has also been made. She no longer has painful bowel movements and luxuriates in them. The constipation, with its enemas and laxatives for twenty-five years, has disappeared. A rectal fissure, present for ten years, has also disappeared. An important development in the last eight months is a change in the type of orgasm in masturbation. This has become less sharp and shocklike. The clitoris has less sensitivity, and she has noticed an increase in vaginal sensation. This brings us to the main correction which has not

been accomplished; namely, her sexual life. The patient now gets invitations from men, but she has regularly turned them down. She is certain now that she can have orgasm because of the exclusive fantasies of normal intercourse and because of the vaginal sensation. However, as she says, she has not had the courage to test herself. Several writers (1, 2) have noted the difficulty in restoring genital sexuality where such a close connexion between death and sexuality has been established as in Ann's case, and it remains to the future to determine what further progress she will make in this field. In the meantime she is glad that ' she has something small and good and not big and showy '.

Discussion

Ordinarily the more mature mechanisms of defence are predominant over the more primitive, but in acute stresses, or where the system is already burdened by a heightened level of tension, the earlier mechanisms again come to the fore. This is clearly observable in Ann's case in each of the four major traumata where archaic mechanisms such as denial, regression, and repetitive discharges intermingle and interact with more advanced mechanisms such as repression and reaction formation.

The material inevitably directed attention to the traumatic aspects, and the repetitions of the traumata in the dreams were the most obvious evidence. Comparison of the manifest and latent content of the patient's dreams with the actual incidents showed that undistorted factors appeared in all. A box is such an element. This appeared in dreams very many times, and, in addition to this, it occurred in associations, in her hobby of collecting boxes and in transference references. The path through the latent dream thoughts led to the coffins in reality, and the uterus symbolically. The colour green appeared in numerous dreams, in clothes she wore, and was referred to over and over again. This came through to the latent dream thoughts which helped to make possible the revival of the trauma of her mother's death.

As will be recalled, her two brothers were the principals in the traumatic sex incident. A dream of this in slightly disguised form occurred on many occasions. In order to illustrate the almost identical repetitions, a few excerpts from these dreams are cited:

(1) Kubie, who was saying analysis was no good, and the therapist, were beating the patient with sticks;

(2) There are two younger men and a woman. One of the men perfected a foolproof gas. They decide to commit group suicide but it fails;

(3) Two menacing Mexicans wanted the keys to her back and front doors;

(4) Two gangsters, one of whom jabs her with a black notebook which becomes a needle;

(5) Two doctors give a woman a treatment. They ' iron ' the pelvis till the woman has a convulsion;

(6) The patient is in bed between two boys. She teases them, but they get serious and threatening.

In addition to this, there were innumerable references to two men conspiring against a woman, and an extensive acting-out procedure developed where she always had to have two men battling against each other; that is, keeping them apart with the aid of the father if necessary.

The evidence for the primal scene was obtained especially through dreams directly, and associations to them. Supplementing these were innumerable fantasies of observing intercourse or being observed. The last example concerns the death of Flora. The most important element here is the flood, and there were many dreams in which floods were involved. Each dream as it came up added its bit to the reconstruction of the incident which led to Flora's death.

I have mentioned some specific features occurring repetitively in dreams. Through the means of part for the whole these have taken on the representations of the original traumatic episode. The event, however, must often be laboriously reconstructed with enough memory traces revived until it is first of all meaningful to the therapist, and finally has an affective meaning for the patient. For example, the description of the mother's death was culled from perhaps eighty hours of therapeutic work. Once analysis resolved a specific problem, the repetitive dreams and other repetitions disappeared. It is assumed that otherwise they might continue indefinitely.

We have mentioned the inhibitions and constrictions of this patient's ego functions. By her hermit existence she avoided practically all types of stimuli. She used another means to avoid a traumatic state, whereby an important part of her ego was split off and partially blocked the perception and affect of her mother's death. A stimulus such as this, however, is a continuous and a gross one and cannot effectively be denied. Ann's frozen state is reminiscent of the apathetic

state of war neurotics much exposed to trauma (15).

Why did the patient not overcome the trauma? As we have seen, she made fruitless attempts all her life to abreact the traumatic situations. In infancy a protecting figure is necessary, however, for the person to try again; to repeat the traumatic experience actively and so overcome it. Otherwise, a traumatophobia is likely to develop and the traumatic experience may be walled off, which blocks the full re-experiencing of the traumatic state. My observations on the war neuroses, and others I believe will agree, indicated that intravenous pentothal for purposes of abreaction given indiscriminately without establishing rapport was of no therapeutic aid. An attachment to the doctor, or some other figure such as a buddy, a nurse, or a wife was necessary. Such patients have lost their protecting figure and are in a state of helplessness, and this figure must be temporarily supplied to them. Ann's exile to the orphanage removed the possibility of a strong loving person. The support of the transference during Ann's therapy made it possible for her to re-experience the early traumatic events. Ann herself was aware of the need for mastering traumatic tensions. She insisted that her brother-in-law drive immediately after the accident from which her father subsequently died. When a patient died at an operation, she would at once try to schedule another identical one. When she fell off a horse, she would promptly remount it and ride again.

Ann's dreams were less distorted than is usual in psycho-neuroses and symbolism was more clear and apparent. This reminds us of the dreams of borderline patients and overt psychotics which are so little disguised. Another patient of mine when under two years of age had his hands tied to prevent scratching. A very traumatic situation occurred when he got caught with his head in the pillow and almost suffocated. For twenty-six years now he has had a recurrent and undisguised dream of suffocation which awakens him in a panic. Sometimes he can hear himself say, 'Turn me over, Mother.' An example of another method of repetition and mastery which the patient used I observed in my own daughter, aged 3 at the time. She had run out in the street, round her mother's car, and was scolded for this. That night she had a dream in which this car was on the sidewalk, all shabby (the car was a 'Chevvy'), its tyres were gone, its paint chipped off, its glass broken, and the doors hanging on the hinges. Immediately she awoke, she rushed to the window to look at the car, and constantly, all day, she told this dream to everyone who would listen. The next day she mentioned it two or three times, and after this it was apparently forgotten.

When traumatic situations in infancy have been severe and there is much internal vegetative discharge, patients not only become traumatophobic but they develop a fear of excitement from any source, including their own instinctual drives. This contributed to the patient's frigidity and fear of orgasm. The ego, always fearful of being overwhelmed, could not permit the increase of excitement preliminary to discharge. Fear of overstimulation also made her ward off interpretations.

Where a trauma is very intense, it is difficult to work out physically in dreams and fantasies, and action with its greater discharge of energy is necessary. This, I think, helps explain the frequent acting out instead of remembering which occurs in the traumatic neuroses.

The interrelations between the psychoneurotic elements and the traumatic elements may become very complex, but with the work of analysis they are often revealed strikingly distinct from each other. The repetitions of the traumatic elements persist into adult life with little elaboration, while the psychoneurotic elements have a rich and variegated development. The criteria for traumatic neurosis noted in the introduction seem to be present.

Trauma is universal, and it is likely that every psychoneurosis will show some of the elements of the traumatic neurosis. In any case, the affective recollection of traumatic events constitutes a large part of the goal of psychoanalysis, and by looking for the specifically traumatic elements we can find a direct path to the traumatic incidents, which began both the psychoneurosis and the traumatic neurosis accompanying it.

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THE ANALYSIS OF AN UNCONSCIOUS BEATING FANTASY IN A WOMAN[1]

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Introduction

In 'A Child Is Being Beaten' Freud (4) describes certain women in whom the oedipal sexual wish for the father is expressed in a succession of beating fantasies. In the earliest phase of the fantasy, the patient, as a young girl, imagines, usually following on the birth of a brother or sister, that her father is beating another child. The meaning of the first phase is: 'My father loves only me and not the other child, for he is beating it,' and this gratifies the girl's jealousy of her rival. This fantasy undergoes repression, and the sense of guilt causes its content to be reversed, so that the second phase says, 'My father is beating me'. Of the second fantasy, Freud says 'this being beaten is now a convergence of the sense of guilt and sexual love. It is not only the punishment for the forbidden genital relation, but also the regressive substitute for that relation. . . .' Yet this second phase 'is never remembered, it has never succeeded in becoming conscious. It is a construction of analysis, but it is no less a necessity on that account.' A third phase becomes a substitute for the second, makes its way into consciousness, and consists of the patient witnessing the beating of a boy by some authoritative man. This fantasy is accompanied by masturbation, and since the boy represents the girl herself, the satisfaction derived is masochistic.

Freud examined the material obtained by the analysis of these fantasies from several points of view. First, because his patients utilized the last phase of the fantasy for masochistic masturbatory release and indeed had no other sexual outlet, being virgins, according to a personal communication from Freud to Marie Bonaparte (2), he elucidated the relationship of perversions to the Oedipus complex. Second, from his finding that out of a sense of guilt the sadism of the first phase of the beating fantasy turned against the self in the second phase, he stated that masochism always originated secondarily from sadism. (Later, however, in *Beyond the Pleasure Principle* (5) and *The Economic Problem of Masochism* (7), he revised his view and postulated a primary masochism.) Third, he sought the origin of the sense of guilt, and by assigning it to 'the agency in the mind which sets itself up as a critical conscience over against the rest of the ego', prepared the way for his later description of the superego in *The Ego and the Id* (6). Fourth, he used the material to refute Fliess' theory that the dominant sex of a person represses the mental representation of the subordinated sex into the unconscious, and Adler's theory that the 'masculine protest' of all individuals causes their feminine attitudes to be repressed. Instead, Freud proposed that what is repressed is whatever is unserviceable to, incompatible with, or harmful to new advances in the individual's development. Infantile sexuality falls in this category but works against repression and provides the motive force for symptom formation. Fifth, and most pertinent for the following presentation, Freud pointed out that the infantile perversion may not continue as a perversion into adult life but may exert its influence in other ways. In this connexion, he emphasized the paramount importance of the second, unconscious masochistic phase of the beating fantasy. The fantasy of being beaten may be expressed in the woman's character and enacted in life. Of this tendency, Freud says, 'People who harbour phantasies of this kind develop a special sensitiveness and irritability towards anyone whom they can include in the class of fathers. They are easily offended by a person of this kind, and in that way (to their own sorrow and cost) bring about the realization of the imagined situation of being beaten by their father.'

The patient whom I shall describe was under the influence of such an unconscious beating fantasy. It did not engender a conscious beating fantasy or a true perversion in adult life, but

[1] Awarded the Clinical Essay Prize for 1956 of the Institute of Psycho-Analysis, London.

analysis revealed how her adherence to it and her attempts to gratify her oedipal strivings by acting it out had deformed her character, distorted her dealings with others, and made an adult love relationship impossible.

History

The patient was a 28-year-old, single, career woman when she came for analysis at the beginning of 1952. Since then she has had over 600 hours of treatment. She sought help because of a painful feeling that life was passing her by. Most of her time, commonly up to sixteen hours a day, was spent at her job in the trade union field. Although she liked her work, she felt she had become merely a dreary drudge. Her current love affair was also unsatisfying. Her lover was a married man with two young children, and although he had been separated from his wife for several years, he seemed content to forgo a divorce. When he spent precious Sunday hours with his children, she felt she was of no importance to him, but bore her unhappiness in tearful silence because she wanted to be fair to the children. She longed for joy and happiness but felt enmeshed in circumstances that denied her these.

As far back as she could remember, she had always felt thus. She had only unhappy memories of her childhood. She was the second of four children, there being a brother one year older, a sister 6 years younger, and another brother 12 years younger. While she could recall her younger brother's birth, she remembered nothing of her sister's arrival or of the time preceding it. The setting of her recollections from the age of 6 was a small crowded apartment in a large Eastern American city during the depression. Although her father was a skilled tailor in the women's garment industry, work was irregular and the family was poor. She remembered herself as an overweight child with unattractive hair and clothes that her parents never tried to improve. She presented a dismal picture of her family life. Her mother was a dishevelled nagger, enslaved to housework, constantly complaining that she was overworked and unappreciated, and forever reproaching the patient for laziness and disobedience. There was continual bickering over the patient's neglect of household duties. She felt she was only resisting her mother's unfair coercion, but her mother claimed she was a bad, worthless, disloyal daughter. She told herself she had the right to refuse co-operation to a mean person like her mother, but the older woman's accusations made her acutely uncomfortable. She considered her father to be silent, cold, and indifferent to her, except when the mother informed him of her refusals to help. Then he would curse her insolence and hit her. Occasionally he would make a dress for her, but she wouldn't lower herself to accept anything from a tyrant who did not respect her natural rights. When he then became enraged at such sullenness, she felt he had revealed his true attitude towards her. Her elder brother was a bully who snarled orders and beat her if she refused to comply. She tried only to ward him off or escape, but was helpless before his superior strength.

It seemed to her that from the earliest days she had been required to take care of the younger children. While other girls played, she supervised her sister and brother. She supposed that she resented the enormous amount of time she sacrificed, but no one could say she had ever harmed them. In fact, even as a very young child she had been the one to comfort her baby sister's tears while no one else bothered. She had never been able to bear seeing anyone hurt or in pain.

She repeatedly spoke of two particular situations to illustrate her treatment in the family. One referred to a ten-day period when her mother was at the hospital to deliver one of the younger children. Which one it was had never been clear to her. She had stayed home from school to shop, clean, and cook. Neighbours had called in to see how she was managing and always commended her thoroughness. But did her parents care? They had given no sign of gratitude, and she had felt crushed. The other situation referred to a scene repeated numerous times at the dinner table. Her mother would serve split-pea soup. The patient loathed this soup—wasn't it a person's right to dislike certain foods?—and would refuse to eat it. Then her father, ignoring her rights, would insist that she eat. She would again refuse. He would slap her, and she would run sobbing to the hall closet to sit on the floor in the dark, feeling abandoned, injured, and righteously defiant. These feelings pervaded her childhood. One of her few consolations was to glut herself on candies and pastries whenever possible. She knew this made her fat and unattractive, but the sweets soothed her wounded feelings.

By the age of 7 she felt she had to look outside the family for friendship. She attached herself to a slightly older girl in a way that was to be repeated several times with other girls and women in the following years and through a large part of analysis. At first she would feel devoted and utterly loyal and believe therefore that her friend could not possibly be interested in anyone else. When the other girl failed to break off with other chums, the patient felt hurt and would marvel that her friend was not even aware of the pain her fickleness caused. Soon she was certain that she was tolerated only if she agreed with the friend's every opinion, and so felt oppressed and stifled.

Concerning sex, she thought she had liberated herself from an intense sense of sinfulness, which she attributed to her parents' prudery and especially to her mother's veiled warnings about bad girls who fell under the influence of white slavers. In childhood she would stare at boys covertly, and because her thoughts dwelt on them as well as on her studies, she felt she attended school under false pretences.

She never had a boy friend openly because that would have been a confession of sexual desire that she feared to reveal to her mother. When she was about 12, her elder brother frequently stole to her bed at night and played with her vagina. She told herself that she acquiesced because she feared him, but knew that she wanted the pleasure. She had also masturbated with a strong feeling of wrongdoing.

During early adolescence, a period which included her younger brother's birth and her elder brother's sex play, she decided she must become an educated, worthwhile person who would achieve a noteworthy position and be independent of her sordid family.

She was an excellent student and had finished her first year of college when her father announced he could no longer help her because everything must go to pay her elder brother's way through a professional school. Hurt by such gross unfairness, she left home for Los Angeles. When the family settled there soon after and insisted that an unmarried girl should live with her parents, she refused to return.

Whenever she saw her parents, she was tense, formal, and taciturn. She visited their home only out of a sense of obligation to help her sister who, she had good reason to suspect, was becoming a sexual delinquent. She was tortured by a feeling that she was accountable for her sister's troubles and would have no peace unless she rescued her. Her younger brother was bright and ambitious, and she was his confidante. They were fond of each other, and she was not troubled about him.

Now that she was away from her oppressive parents, she wanted to obtain fair play, justice, and freedom of opinion for herself and others. She abhorred violence as unworthy of decent people. The least powerful person's rights should be defended and special privilege opposed. She became interested in trade unions and felt that their work embodied many of her sentiments.

In her early twenties she began clerical work for a small organization that did economic research for trade unions, presented lectures on current legislation to union members, and assisted in the preparation of labour disputes that were to be argued before an arbitrator. She educated herself in a particular aspect of labour law and became an authority in the field. Unions requested her to appear as their representative in arbitration cases. These were quasi-judicial proceedings that required skill in cross-examination of witnesses and in the development of evidence, abilities usually expected only of highly trained lawyers. She undertook this work, and her opponents were always expert attorneys. She soon established a reputation by winning difficult cases, and the demand for her services increased. But she received a clerk's wage for professional work ordinarily delegated to lawyers.

She regarded her job not merely as a livelihood, but as a mark of distinction and a credential of worthiness. She relied on it to show she was useful, intelligent, and generous. However, she was certain that her colleagues tolerated nothing less than complete dedication to work. Therefore she felt compelled to give it precedence over all personal concerns. Were she to take time for a concert, or clothes shopping, or even cleaning her apartment, she feared condemnation as self-indulgent, insincere, and disloyal. Despite her conscientiousness, she expected her integrity to be questioned if she made the slightest mistake. She considered arduous work an inseparable part of her existence, but complained that it deprived her of all of life's pleasures.

After leaving her parents' home, she had several love affairs, all similar in pattern. She was always attracted to an older, married man. She would assure herself that his marriage must have been unhappy before she had ever met him. Soon after their sexual relations began, she would suspect that he was using her as easy solace for his marital discord. Convinced that she really meant little to him, she would become withdrawn and unresponsive to his overtures and sit silently before him with head averted and tears tumbling down her cheeks. He would become impatient and sharp, and she would feel stricken by his callousness. They would see each other less and less, and she would feel hurt and abandoned.

The affair at the time that she sought help was hastening towards such a termination. She was over-eating, and none of her more beautiful clothes fitted her. She was puzzled and ashamed that she always violated her diet just as she was regaining an attractive figure. She felt an ever-present, mounting discontent and could find no way to allay it. When confronted with a difficult problem at work, her policy was to seek objective consultation, and now she decided she must approach her personal problem the same way. So, overworked, overweight, and unhappy, she came for treatment.

The Analysis

From the beginning of analysis the patient felt that her present difficulties were related to her past life, but in a particular way. Her parents had hated her and had made brutally clear their opinion that she was worthless and bad. As a result, domineering persons found it easy to exploit her because she was now so anxious to avoid criticism. Pleasing others left little time for her own pleasures. She hoped treatment would toughen her to the harshness she was exposed to, and so leave her free to live more fully.

In almost every hour for the first six months she described someone's overbearing behaviour and her inability to cope with it. The woman who was her current intimate friend had ridiculed her seeking help and demanded that she develop enough backbone to handle problems by herself. A union official, disregarding her closely planned work schedule, had barged in without an appointment and compelled her to waste valuable time on a trivial matter. Her employer had insisted she deliver a

lecture when she was already giving every waking moment to preparing an important arbitration case. Because some unions had been remiss in paying their retainer fees and her organization's scheme had dropped, her salary had been suspended and she had been forced to borrow money to live on.

Her manner in relating these incidents was always the same. She was never indignant or angry, as often seemed appropriate. Instead, she would be silent for several moments while tears welled up in her eyes. She would avert her face and dab at her wet cheeks with a handkerchief. Then in a broken, choked voice she would reveal her latest humiliation, adding that when she was treated unfairly she only wanted to run away and cry in private. It was, she said, the same miserable feeling she had had as a child sitting in the dark closet after her father had hit her.

Yet throughout the time that she was depicting these tribulations, she was having experiences of quite a different kind. But these she referred to hastily and fleetingly. While visiting her woman friend, she imagined cleaving her skull with an axe. During nights spent with her lover, she sometimes feared she might unwittingly kill him in her sleep, and would awaken in a panic, gasping, 'Have I done it?' When a woman colleague went for surgery, she pictured the woman dying. She made early morning business appointments but would oversleep and keep her clients waiting.

Such thoughts and behaviour she regarded as horrible and alien to her nature. I repeatedly pointed out her destructive impulses and her guilt about them. I said that to deny these impulses and allay the guilt, she needed to arrange to feel like an innocent who suffered at the cruel hands of others. She replied that first of all she did not *want* to hurt anyone, and secondly, others *did* mistreat her and she surely was not responsible for their attitudes.

When she reported having had to accept a suspension of salary, I asked whether she would negotiate a trade union contract that required a worker to forgo his wages and go into debt if his employer became pinched for money. She was incredulous. Was I serious? Why, you couldn't ask a poor worker to subsidize his employer. By all logic and fairness, the employer should be the one to borrow money, if necessary, to pay his obligations. Yes, she could see my point, but she had never thought of her job this way. When anyone misused her, she just felt 'devastated, crumpled inside, helpless'. That was why she could not stand up for herself. And anyway, why should she have to ask for what was due to her? She should not have to remind others of her rights and needs. I then said that she seemed reluctant to change the conditions that hurt her. No, that was fantastic. She was sick of being stepped on. Maybe it was time she did something about it. A few days later she said that she had asserted her rights at a staff conference at work and had won not only restoration of her salary, but exemption from lecturing and relief from some office chores. She was amazed to learn that everyone had assumed that she could manage financially, since she had not objected to the pay suspension. She was elated over these gains, but within a few days felt tense and uneasy and said it seemed wrong not to feel unhappy.

As hardships at work diminished, her behaviour in the hours became striking. She was silent for long periods, alternately wringing her hands and clutching the skin of her forehead. Cringing on the far side of the couch, she darted glances at me, her expression apprehensive, her eyes wide and pleading. She appeared to be in agony. I said she behaved as though she were a helpless victim and I a wanton torturer.

During the next few weeks she found herself wanting to injure various people and feeling intensely guilty. In each instance, she caught herself reversing the situation by constructing a fantasy in which the other person was vicious to her. She noticed that she had then experienced a pleasurable righteous indignation and relief. She had then realized, she said, that she did want to feel helpless and abused, and that she did not want to give up this feeling. It was 'like a protective blanket; it made everything all right'. She recognized how readily she had always found pretexts for invoking a feeling of being injured. If anyone spoke crisply to her, he was being rough and scornful. If a friend greeted her with insufficient enthusiasm, he was showing contempt. If a colleague demurred from her opinion, he was being dictatorial.

Now toward the end of the first year of analysis, in a session just before a week-end, I said that in the light of her need to feel mistreated and hurt, I wondered if her childhood had been as grim as she portrayed it, and whether she had played a rôle in making it so. She was sceptical. The idea seemed highly improbable to her. She had no doubts about how her parents had treated her. At the beginning of the following week, she appeared puzzled and tense. On the intervening Sunday she had felt an inexplicable urge to visit her parents' house. She had picked up the family picture album and turned the pages idly. Suddenly she had been startled by a photograph that seemed utterly new to her. There she was, a little girl of 5, beautifully dressed and with long blonde hair tied in ribbons. Her mother stood smiling down at her. As she described the picture, she burst into tears. 'It's unbelievable. How could I have forgotten those days? That was the happiest time of my life. I felt like a princess.' She recalled her parents' adoring approval of her childish preening and gay dancing. It had seemed to her that her mother and father, while fond of one another, each reserved his deepest affection for her, and she had considered herself the beloved centre of the family. Her thoughts turned repeatedly to a pleasant scene of her doting mother giving her hot buttered rolls and cocoa in a bright clean kitchen.

She felt that the sunny contentment of this scene epitomized those early years. With these recollections, she became fearful that her entire view of her life was being shaken. Had she built up a false picture of herself and her parents? She felt that she could not bear to change her attitudes towards them.

Her childhood was now separated clearly into two distinct periods: an earlier, happy one when she felt loved and secure, and a later, dismal one when she was antagonistic, provoked punishment, and felt hated by her parents. The question was, why had she changed?

The material of the next four months began to answer this question. She dreamed that an older woman stood barring her way and that suddenly a shower of water gushed from between this woman's legs. She then recalled that when she was ' very young ', that is, 6, she had seen her pregnant mother's bag of waters break and run down her legs on to the floor, but remembered nothing of her own reaction. Then she dreamed that she was distraught because she had dropped a baby entrusted to her care and broken its leg. Her associations led to her baby-sitting jobs at the age of 12. With great guilt, she told of one baby she had deliberately pinched hard because she hated his parents, nominally for being slow in paying her. She thought of her own sister and younger brother and now felt glimmerings of her hatred of them as intruders in her paradise. She recalled a simple-minded uncle playing with her sexually as a child, and her never protesting. And she remembered regarding her mother as slovenly and not good enough for her father. The period of her taking care of the house while her mother was in the hospital began to emerge in a new light. Whereas it had been a prime example of her self-sacrificing and unappreciated suffering, now she remembered her joy in picturing herself as the mistress of the house. She had prepared her father's meals and clothes happily, and he had been proud of her. The night her mother had gone to the hospital, she had slept in her parents' bed. Her father had come home in the early morning hours and awakened her to report the baby's birth. She related that he had then climbed into bed with her, but immediately retracted this statement, saying she felt confused. ' Maybe he went to sleep with my older brother.' These events actually occurred at the time of her mother's last pregnancy with the younger brother when the patient was 12, but she had a persistent fantasy that she had taken care of the house and her father when her sister was born, although she was then only 6. I said that she no doubt had wanted to at that time as well.

She began to experience in the transference the feelings of that early time. First the defensive aspects appeared. She felt no active desires or demands. It was only that my aloofness and indifference hurt her, so that she had to bite her quivering lip to keep from crying. She became preoccupied with imagining how I would react were she to remain away from the sessions. Would I be angry, berate her, perhaps even strike her? She was indignant at the thought of such humiliating treatment from me, and yet felt fascinated by the idea that I might behave in that way. I said that only a person emotionally attached to her would be likely to be moved to such anger by her absence; perhaps what fascinated her was the intimacy implicit in being struck by me. She then dreamed that she was staunchly defending herself in a fight with an unknown man. He threw her on a couch, and she suddenly felt he would unjustly suspect her of wanting sex instead of a fight. As she related the dream she felt intensely guilty and said, ' When my father became angry and beat me I always felt I must keep it secret from everybody. I used to think I was ashamed of his behaviour, but I just realized that wasn't it. I was ashamed of myself. I *wanted* him to hit me.' Now she revealed that she wanted me to see no other patient. She felt that any time I gave to anyone else was taken from her. She was astonished at the reality of her possessiveness. For the first time, she realized that she wanted to be every friend's favourite and that, in her affairs with men, she relished winning over another woman. She reacted to this insight by spending hours in searching for a job for her sister and in doing the work of a woman subordinate whom she had permitted to become lax. Then she complained of feeling deprived by these impositions. I pointed out that she played the exploited, injured child to deny her competitive, destructive impulses toward women and her sexual interest in men.

At this point, about the sixteenth month of analysis, the material abruptly veered in another direction. She started to complain that men had a superior attitude towards women and wanted to relegate them to menial household chores. She was proud that she had risen above such tasks. She felt hurt by the derogatory manner of one particular lawyer opponent whom she described as ' arrogant, a whip-lash, a lord of the earth, powerful '. He was just like her elder brother. This brother was competent and respected, and she now realized that she wanted to be just like him. Her work, she felt, was a man's work, and she wanted to be impressive in it, like a man.

The transference, now centring on her feelings towards her elder brother, assumed a new character. Her silences returned, but were not of the former tearful, suffering kind. They now had a jaw-clenching, antagonistic quality, which I pointed out. She then admitted her feeling that to talk was to acknowledge my superiority, while silence was a way of proving her equality. She began coming to the sessions half an hour late and stated she wanted to show she didn't need my help. She dreamed that a man was being beaten by a gang while she stood by doing nothing and telling herself that she was

helpless against the men. Her associations revealed that she felt ' hypocritical ' in the dream, that in a ' mocking way ' she was saying, ' You really can't expect a weak woman to help you.' She recalled that in fighting with her brother she had wanted to seize his penis and crush it. And then she recognized that behind her mild and plaintive demeanour towards her lawyer opponent lay a fierce urge to claw, smash, and beat him to a pulp.

During one session, she unconsciously caressed an ear-ring while she talked. I called her attention to this. Her hand paused, and then she suddenly snatched both ear-rings off, hiding them in her palm. ' I don't want to show them to you. I never realized. I feel I've never really looked at them before. I'll never wear them again. My God, it's so obvious. I feel like I've been flying under false colours.' Then she held up an ear-ring. It was a pendant phallus with a small ball on each side. She left the session determined to repeat to herself, ' I have no penis ', but what came out was, ' I have a penis '.

Now she seemed driven to function as a man. She stated that only her work was important to her and redoubled her attention to every detail of her cases. She wanted people to think of her as a perfect worker. At the same time, she disparaged herself as a woman. Of course other women were more attractive to men and more successful with them than she was. She neither expected nor cared to compare favourably with such women.

I said that by her immersion in work she seemed to be protesting that she had no interest in men; that she competed only as a boy, and that she renounced any claim to being a woman who competed with other women. She responded with the realization that until the birth of her sister she had felt beautiful and confident, and that only after that had she allowed herself to become fat. She further realized that only after the younger brother's birth had she felt convinced that no man would ever love her and became determined to win status by her intellect. She dreamed that her father was shouting abuse at her elder brother and handling him roughly. Her associations were that in reality her father was very proud of his scholarly son. She had envied her brother's position and tried to emulate his attainments. She said, ' I just had a horrible thought: I would *like* to see my father mistreat my brother; then I'd feel like the favourite.' Now she felt the truth of the interpretation that in her intense efforts to be a boy she was only taking a devious route to the goal of possessing her father.

The analysis was now at the end of its second year, and the material returned to the subject of her feminine strivings and their attendant anxieties. While sitting in the waiting room, she felt unhappy on hearing a high-pitched voice in my office and thought, ' He has chosen another woman.' When I pointed out that she felt betrayed, she recalled a new detail of the time she had managed the house in her mother's absence; that when her father had announced the baby's birth, she had felt bitter towards him.

During the more frequent visits she was now making to her parents, her father often kissed her cheek, and each time she felt a surge of guilt towards her mother. She had the same reaction when a friend's husband embraced her affectionately. She had to assure herself that she was not responsible, but recognized she had wanted his attentions. About the same time, she was shocked to see her sister brazenly hug her father before their mother's eyes, and was certain that her mother felt excluded and hurt.

She revealed now that she and a man Roy, whom she had known for six months, were in love. Recently he had proposed marriage, and ever since then she had felt an amorphous dread and had avoided sexual relations with him. Soon the feeling crystallized into a fear that bodily harm would befall her. Then a terrifying dream occurred that clarified the situation. In it, a woman was about to have a baby. Her membranes ruptured and a pan was put under her. She was roughly handled. Someone forcibly put a hand into her uterus to tear something out. It was a bloody mess. The woman was mortally ill. As she related the dream she sobbed in anguish that the woman in it was herself, and she now knew that she had always feared a pregnancy would kill her. The reason for this expectation was also clear, she said. Anyone so brutal as to hate her infant sister and turn her mother into a careworn drudge deserved to die. She had been avoiding Roy because she didn't want him to arouse her desire to have children, a desire that would prove fatal.

After this partial insight into her wish to destroy her mother and sister, she felt hopeful, optimistic, and free of tension, but not for long. She had introduced Roy to her latest woman pal, Maggie. Soon she felt certain that he no longer loved her but was attracted to Maggie, and that Maggie, with cold-blooded, disloyal selfishness, was setting her cap at him. She said there was no actual evidence of this, yet she felt helplessly caught up in an inexorable process that would end only in their going away together and her being left abandoned and isolated. The hurt was unbearable. She could neither sleep nor work and cried incessantly. She could think of nothing but her impending loss of Roy. I reminded her that she had told me Maggie had never had much luck in getting a man. Yes, she replied, that was true. She felt incomparably better off than her friend. She was sure that Maggie must be full of longing and loneliness and very envious of her. ' Before I was sure of my attachment to Roy and while Maggie was the most important person to me, I was comfortable. But as I fell more in love with him and grew away from her, I became very uneasy.' She dreamed that Maggie was dancing in front of Roy to entice and excite him, while she stood by feeling bereft. Her associations led to recollections

of her own seductive dancing before her father when she was small and of childhood daydreams of becoming an entrancing ballerina. She added that although usually graceful, she was awkward and stiff when dancing with Roy. To dance well, she said, one had to be responsive to the man, able ' to blend and be as one with him '. She felt afraid to display such closeness to Roy. I said that she attributed to Maggie her own competitive feelings towards her mother, and that she felt guilty about winning Roy as she had felt guilty about wanting to win her father from her mother.

Within a few weeks she accepted Roy's proposal, and in a short time they married. She was astounded by her parents' expressions of love for her. They would not hear of her plans for a perfunctory, inconspicuous ceremony. Out of their meagre savings, they bought her a beautiful wedding dress and paid for a real celebration feast to which they insisted she invite all her friends as well as the family. At the wedding she was intensely moved by their glowing pride and affection.

In the first session after the honeymoon, she related another memory of the time she was mistress of the house in her mother's absence. She recalled feeling deposed and relegated to the status of a little girl when her mother had come home and taken over again. Throughout the honeymoon she had been depressed and plagued by the idea that she ought not to be a married woman. Now she wondered if this was because she had ' wanted to be the woman of the house, I mean the wife and bearer of children when I was a girl in my mother's home '. A dream led to confirmation of this idea. In it, her sister was in a cave where she should not have been, and her mother was dying of a growth in her uterus. She felt responsible. While telling this dream, she made a slip of the tongue, saying, ' My baby ', instead of ' My sister '. She said, ' Everything points to my feelings at the time of my sister's birth. I can see the indications that I wanted to have the baby, that I didn't want my father to have anything to do with my mother. Even that I hoped she would die. But somehow I don't really know these things.'

But she now experienced in present-day life all that she denied knowing. She felt a chronic, implacable hatred of Maggie and frequently imagined beating her senseless. At the same time, she said that she knew now that these feelings had nothing to do with Maggie, and in fact she had lately felt afraid to be with her mother lest she ' inadvertently ' hurt her. Her mother went to visit relatives, and the patient eagerly called her father to inquire how he and the children were managing, but recognized that she expected him to reprimand her ' for trying to be the mother of the family '. She noticed her own excitement and fear when she witnessed a friend's adolescent daughter behaving seductively towards him. And then she recalled that when her father had come to bed with her on the morning of her brother's birth she had felt great physical excitement.

With the recovery of this memory, she completely withdrew from sexual relations with Roy and began to overeat grossly. She spoke of wanting me to question and guide her and imagined herself a baby whose father led her gently by the hand. And she noticed herself seizing on Roy's most trivial remarks to feel unloved, cast out, and hurt by him. I interpreted these reactions as her saying, ' I'm a little girl interested only in food, not sex. I'm a baby who wants only guidance. I'm not a girl capable of winning a man. I'm only an unhappy child, despised and mistreated by my father.'

Sexual desire then returned in full force. Her pleasure in intercourse was greater than ever and she felt an active desire to have a baby. However, she now felt she should not talk about such things to me because I might find them embarrassing and shocking. She pictured me as leading a cloistered, ethereal life. When I said she preferred to consider me asexual, she thought of a teen-age neighbour boy who had been very upset to learn that Professor Einstein had a son because he had been sure that such great men were above sex.

She then began to report a series of difficulties at work and at home. She felt ' unable to understand ' legal problems which formerly had been clear. She ' couldn't see ahead ' to anticipate new developments during case argumentations. She had ' misconstrued the facts ' in a political discussion with Roy, and he had chided her that she ' ought to know better '. She had been feeling anxious but found herself muttering doggedly, ' I won't think about it. It will go away.' I said that she wanted to deny her knowledge of the facts of sex. She soon recalled playmates telling her as a child how babies were made and her thinking, ' then he, and she, and everyone must be made that way '. For the first time she now remembered her mother's enlarged abdomen when she was pregnant with her sister and realized how completely she had ignored her mother's changed appearance. She had known that her father was implicated, but recognizing that he was in fact intimate with her mother had caused her to feel painfully betrayed. However, she had not long admitted to this knowledge, for, as she noted with amazement at her self-deception, ' I've never been able to think of my mother and father doing anything sexual. I always thought of my mother as utterly naive about sex.' When she and Roy had first rented an apartment, she had been sure her mother would be terribly embarrassed to see their bedroom.

Her motive for denying her parents' sexuality began to emerge. She admitted that whenever I took a vacation she felt a jealous rage at my wife and wanted to hurt her. With this admission, she became fearful that some disaster would befall her mother: a fatal accident would occur, or some minor illness would take a morbid turn.

She again fell into long silences and with limp fingers plucked weakly at the couch. She would

start to speak in a small voice only to say, 'I'm confused. I can't. I have to stop.' I said she presented herself as a child so weak as to be incapable of harming anyone and so frightened as to be spared blame. She agreed, saying she feared her feelings towards her mother and my wife. Then she remembered her secret fury when her mother had come home from the hospital with her newborn sister. Within a few days her sister had fallen seriously ill, apparently of an infected sinus of the neck, and had had to be returned to the hospital. She had been told the baby might die and felt herself to possess an appalling evil power. As she recalled these events, she felt the same horror as at that time. She said, 'This is why I've dreaded seeing sickness or suffering. I always felt to blame in some way.'

At this point she reported a pleasurable dream in which I proposed having sexual intercourse with her, but said she felt too ashamed to discuss it. She could only say, with the greatest reluctance, that the important feature of the dream was that I had taken the initiative. Before each session for the next several days, she found herself dwelling on the old idea that I was angry and brutal to her, and she would arrive for the appointment feeling morose, reproachful, and uncommunicative. She said, however, that the feeling of being mistreated by me lacked its former conviction and seemed rather contrived. Eagerly she suggested that perhaps she needed to feel abused to allay guilt for having dreamed of intercourse with me. But she still refused to amplify her sexual thoughts concerning me. She insisted tenaciously that the whole subject was forbidden and bad. To participate in any talk about sex, she said, was as improper as to permit her father to kiss her when she visited the family. I asked what was wrong with a father kissing his daughter. She was startled and bewildered. 'Well, when you put it that way, there's nothing wrong with it, I guess. Why, you're implying there is nothing sexual involved!' Her first reaction was relief, but soon she found, to her great surprise, that she was very angry as well. 'I keep wanting to say that his kisses certainly are sexual.' I then said that she wanted to believe that both her father and I had sexual intentions toward her. To express her own erotic desires would lead to the painful realization that they were not reciprocated, and she refused to accept this. She could not arrange for her father to love her sexually, but she could manage to feel beaten by him and so preserve an illusion of physical intimacy between them. At this she cried, 'It's better to be beaten than ignored.'

Following these interpretations she began to complain of feeling trapped in her marriage. She was dissatisfied and disappointed. How could she have been so blind to Roy's inadequacies? She regarded him as a stranger. She longed to go back to her childhood and live it over. She felt cheated of something essential. To have a child by Roy would be to sacrifice irrevocably all chance of getting the best. The father of her child should be someone 'exceptional'. Then, shyly, she said that were it someone like me, she could feel satisfied. I said that she was still hoping that her father would give her a child, and that she seemed determined to remain available for him and accept no one else. She wept quietly, recalling her childhood feelings for her father. He had been unfaithful, but she would be loyal. She would never care for anyone else but him. Some day he would realize her worth and turn to her. 'But that can never be, can it? Oh, I feel so sad.'

Shortly after this, just past the 600th hour of analysis, she said that recently she had thought many times of the bitter scenes with her father over her refusal to eat her mother's soup. The real meaning of those incidents had dawned on her. 'It was a fight between my mother and me for my father. I was trying to get him to take my side, to say he loved only me. I wanted her to drop dead. You know, I really never gave up hope. It's true, but even a little while ago I couldn't have said it. I would have expected my tongue to be cut out."

Here she summarized the elements of her conflict: the unrenounced desire for her father, the jealous destructiveness towards her mother, her guilt and her fear of retaliation. The relationship between these factors has become increasingly clear to her, and she appears to be attaining a new perspective of herself and her parents. For the first time she has begun to feel important in her own right and has been able to believe her husband loves her and to love him. She had a dream in which she returns a large, floppy pocket-book that she has taken from an older woman and eagerly seeks for her own trim, highly valued purse which has been misplaced. She interpreted this dream herself. The purses, she said, were female genitals, and that only as she has renounced the desire to destroy her mother's womanhood has she felt freer to develop and enjoy her own.

She feels much more relaxed with both parents. She sees them, not as tyrants, but as people who were not able to understand their children's passions because of their own emotional conflicts and who therefore resorted to moral censure to suppress disquieting attitudes. She has realized that they are both shy and timid and extremely appreciative of her interest and praise. They often seek her advice on family matters now and commend her wisdom and sensitivity. She now considers her elder brother not arrogant, but merely reserved, and acknowledges with admiration his loving patience towards his children. She no longer feels to blame for her sister's woes and has lost the need to save her.

One of the most impressive results of analysis to her has been the change in her feelings about work. Now it is a job that she does efficiently and decisively; not a task-master that she needs to appease. The need to expiate guilt and to seek the surreptitious pleasure of being the beaten girl having decreased, she no longer invites or assumes excessive

assignments but limits her efforts to ordinary work hours. Most important of all, she does not look to work to provide her greatest gratifications. While enjoying many intellectual interests, she longs for fulfilment as a wife and mother. This goal, so long feared and forsaken, now seems possible of achievement.

Summary

The patient, as long as she was the younger of two children, felt that she was the beloved little princess of the family. Her self-centred contentment was bolstered by the illusion that both parents loved her more than they did each other. In this way, she postponed dealing with her oedipal conflict. But when she was 6 came the shattering evidence of an intimacy that excluded her. Her sister was born. She wanted to destroy mother and infant and have father to herself, but guilt, fear of retaliation, and the impossibility of attaining her aims caused these wishes to be repressed. Instead, she identified with her intended victims. She provoked attacks from her parents, became the harmless, innocent, injured girl, and in this way obtained, as Freud describes, both punishment and disguised libidinal excitation from her father. Regression to orality also occurred. By over-eating, she tried to obtain a substitute gratification for her frustrated genital urges. Obesity was a negation of her wish to be sexually attractive to her father and thus allayed guilt. At the same time, it probably expressed in oral terms a wish to be pregnant by him, but this has not been clearly established.

At 12, stimulated by her resurgent, pubertal sexuality, the mother's absence from home for the birth of the younger brother, and the father's sleeping in the same bed with her, her fantasy of replacing the mother revived, only to be frustrated again. The incestuous and destructive desires intensified in puberty were again transformed, as at the time of her sister's birth, into a need to be beaten. Now, however, the beating was not physical, as it had been in childhood, but psychical, and it was not administered by her father but by fate. She also elaborated an additional means of dealing with her oedipal mortification and guilt: she would become an intellectual boy, like her elder brother. By winning recognition in that way, she could assuage her injured self-esteem, deny competition with her mother, and still seek, in the guise of a boy, to win her father.

Her choice and manner of work were meant to show that she was both a bright boy who merited admiration, but was exploited, and a devoted sister who served others, protected the weak, assumed everyone's burdens, and sacrificed her own desires. With her intimate women friends she played the rôle of the loyal, obedient daughter betrayed by a cruel mother. With her lovers, she was the undemanding child, mistreated by an angry father.

In all these activities and relationships she felt beaten by others. Feeling beaten fulfilled several functions. It was a demonstration that she was a passive victim and not an active attacker. It was a denial that she sought forbidden pleasures from her father. It was an avowal of weakness and non-competitiveness with her mother. It was a plea to be spared punishment since she had suffered already. But it was also an expression of her erotic attachment to her father and of her hope that he would gratify her. In feeling beaten she unconsciously insisted, 'My father does indeed have physical relations with me.' In her efforts to obtain this feeling by alloplastic involvement with persons in her environment, she resembled the 'acting-out personalities' described by Alexander (1) and Glover (8). By attributing her unhappiness to being beaten, she avoided seeing its true origin: that neither her father nor I had sexual intentions towards her. In this way, as Spiegel (9) describes in another connexion, she forestalled acknowledging the reality of her oedipal defeat and the necessity of relinquishing her oedipal attachments.

In analysis she sought to perpetuate the feeling of being beaten. When her own activity in arranging injury to herself was exposed, she began to experience her childhood sexual and destructive impulses. At that point she fell back on a second line of defence, as she had in puberty, by emphasizing her masculine strivings and minimizing the feminine. As this manoeuvre was analyzed, her oedipal desires, hopes, and fears emerged more fully, and she has had an opportunity to examine and resolve them, and make a new attempt at integration.

Freud thought that beating fantasies are more prevalent than is generally supposed, and Bonaparte regards them as even typical reactions of the young girl to her oedipal struggles. To some degree, the need to feel beaten and the pleasure in it persist in the woman's subsequent development. These tendencies, which assume pathological proportions in the masochistic perversion, can also contribute to various attributes, some negative, some positive, but all generally considered feminine. Among the former are the propensity to silent reproach, ready tears and martyred forbearance. Among the latter are willingness to bear hardship, generous devotion, and steadfastness in adversity. And even further away from pathology, these same tendencies, as Helene Deutsch (3) points out, may help prepare the way for that pleasure in sexual receptivity which is an essential trait of femininity in the normal woman.

A Follow-up Note

Since this paper was written, the patient has become pregnant. Although she feels pride

and happiness over this event, she has had an exacerbation of apprehension. This appears to arise from two sources. First, as a prospective mother she is again experiencing and examining her expectation of talion destruction for her oedipal hostility toward her mother's pregnancies. Second, reacting to the coming child as to a new brother or sister, her pre-oedipal fears of displacement and loss of love have been reactivated. Feelings of being cheated, receiving less than her due, being abandoned, and longings for tender care, previously warded off with an attitude of defiant self-sufficiency, have come to the fore. With the working through of this material, the prospects appear good that she can arrive at the end of her pregnancy and of her analysis with a truer feeling of independence, a mother in her own right.

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PSYCHO-ANALYTIC PSYCHOTHERAPY CONDUCTED BY CORRESPONDENCE[1]

REPORT OF THERAPY WITH PATIENT HOSPITALIZED FOR TUBERCULOSIS

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About three years ago, special circumstances led me to undertake psychotherapy by correspondence with a patient who was then hospitalized for tuberculosis. This is a report of the experience that followed.

The Literature

The use of writing as a means of communication in psychotherapy is not without precedent. Freud's correspondence with Fliess, his written associations to his own dreams and acts, formed an important part of his self-analysis. Freud's *Analysis of a Phobia in a Five Year Old Boy* was in part carried out by correspondence with the boy's father. A similar method is reported by Leo Rangell in 'Treatment of Nightmares in a Seven Year Old Boy.' E. Pickworth Farrow, in his *Psychoanalyze Yourself*, describes his attempt at self-analysis, in which, like Freud, he wrote down and analysed his own free associations. Because of his deafness, David Farber's patients have written their associations instead of speaking them, and Farber reports on his observations in 'Written Communication in Psychotherapy'.

Grotjahn in his Gimbel Lectures describes an exchange of letters with an adolescent girl during a year's interruption of analysis which began after the 112th hour because of absences of both patient and analyst. The patient initiated the correspondence and it continued without specific prearrangement. In his commentaries to the correspondence, Grotjahn states, he attempted 'to gain time with the patient, to support and encourage her, to keep her going, and to stay in contact'. At the end of a year, the patient returned for two hundred additional analytic hours.

From this experience Grotjahn decided that 'such letters can serve the purpose of keeping contact with the patient, and perhaps if done properly can continue the patient in the process of working and living through'; that 'such correspondence is limited in its usefulness, but has made it easier for my former patient to return later in treatment'. He believes that 'the letters did not play a great part in the later analysis. There was no evidence to consider them as building obstacles in the later progress of her analysis or in the formation of her transference neurosis'. He adds, 'In her associations later she stated that I was not much closer and not much more distant to her than when I was sitting in my office on my chair behind the couch during her analysis. I found this true in several other cases where interruption of analysis was indicated or unavoidable, and where correspondence would bridge the gap between the two different chapters in analysis before and after the interruption'.

At the end of the analysis, Grotjahn concluded: 'In terms of a transference neurosis, we may express the possible therapeutic value of such correspondence in a slightly different way. It is possible for a limited period of time to maintain by correspondence certain transference relationships. In such a transference relationship only general interpretations may be given. That means not at all that such interpretations must be shallow or banal. It depends upon the patient's resistance how much the patient can accept of such interpretation, and therein lies the great hindrance of correspondence, and the limitation of it. Resistances cannot be properly analysed by interpretations in letters. If the patient comes to the end of that period of willing working through which follows successful therapy, then the usefulness of letters will have

[1] This paper was considered for the Clinical Essay Prize for 1955 of the Institute of Psycho-Analysis, London. The judges found that owing to the nature of the therapy the paper did not comply with the rules set out for the Prize. The judges recommended the paper for publication in this *Journal*.

reached an end. Such a period of working through can perhaps be deepened and prolonged and used as preparation for later work in the office.'

Added to these instances is the fact that psychiatrists at times may use writing or the telephone (Leon Saul) as a temporary means of communication or support. For instance, Freud wrote letters such as the famous note to the mother who was so concerned over her son's homosexuality. Karl Menninger lately expressed his general opinion that in quite a lot of experience he has had great conviction of improvement as a result of letters written to people.

None of the instances cited above, however, constitutes a deliberate attempt to do psychoanalytic psychotherapy directly with the patient by correspondence only, nor have I found any report on such a case. Therefore this report of psycho-analytic psychotherapy by correspondence should be of some interest.

Introduction to Case

From the voluminous material at hand after several years of daily correspondence between the patient and myself, I have selected those portions that deal with the patient's past history, current life situation, and initial attitudes towards the therapist, followed by three episodes of importance to the course of the therapy. The first reveals some important historical material, including the revival of repressed memories, and illustrates the patient's basic attitudes and response to therapy; the second concerns the patient's analysis of two dream elements that led to some understanding and partial relinquishment of a defensive regression; and the third points up other changes in the patient. Finally, I shall present excerpts from a series of letters we exchanged in order to illustrate the character of my interventions and the ways in which the patient responded specifically to these. This discussion, I hope, will show how such familiar phenomena of psycho-analytic therapy as transference, unconscious material, instinctual drives, defences, and so on, manifest themselves, though correspondence is the medium for communication; and will enable the reader to evaluate letter writing as a tool for a psycho-analytic type of therapy.

Referral

The patient, Mary S., a married woman of 33, was referred by her physician, a specialist in diseases of the chest, who had treated her for several years for tuberculosis. He stated that Mary had had one lung removed because of tuberculosis and that she now had tuberculosis in the remaining lung. He stated that Mary's physical prognosis was very poor. He felt that her attitudes and conduct were dangerously interfering with her ability to cope with the illness; that she was literally committing suicide; and that she was thereby making life intolerable for both herself and her husband. He expressed hope that psychotherapeutic aid might at least lower Mary's tensions.

Initial Interviews

When Mary was first seen in several office visits she was small and frail, weighing about 75 lb. Her voice was low and hoarse, suggesting a laryngeal lesion. A loud whistling sound came from her chest with every word and breath, and her respiration was obviously laboured. To hear what she said, one had to sit very close to her. She had brought with her a carefully written personal history, but emphasized only her hope that I would help her carry out her threats to leave home and live alone, although her mental and physical status made these plans obviously unrealistic.

My diagnostic impression was: a character disorder with oral traits predominating, associated with a marked tendency to somatization. The chances for effective psychotherapy seemed slight.

Shortly after these visits Mary had a haemorrhage from her remaining lung that required her immediate hospitalization. I saw her briefly twice at the hospital, and then discontinued further visits because the trips took too much time and the outlook for psychotherapy was poor. Thereupon Mary's husband, alarmed and desperate over her depression and suicidal behaviour, came and urged me not to give up, to do something.

Despite Mary's attitude when I had seen her, I had been struck by the personal history she had written and brought to the first interview. It showed a capacity for interest and understanding not otherwise observable in her behaviour. Psychiatric assistance, however, could not be given by face-to-face interview because office visits were impossible and the patient's voice too weak. The idea then occurred to me of trying to conduct psychotherapy by mail, if the patient were willing. Confronted with her moribund condition, there was nothing to lose and perhaps something to gain. In suggesting this course to her husband, I warned him that the procedure might be more disturbing than usual to the patient, and such disturbance harder to handle, without the safeguard of personal observation in the face-to-face interview. I also warned him of the possibility of unforeseen difficulties and risks. At his insistence, I consented to try the method if Mary agreed.

Method

Although Mary had initially expressed resentment over the referral and, as mentioned before, had then demanded that I help her in her wish for a separation from her husband, she agreed to this attempt at psychotherapy. I instructed her to write to me every day about anything that was of interest or concern to her. As the result of experience it

eventually became advisable to ask Mary to write at a specific time each day and to confine her work to one hour. Otherwise her choice of the time and the amount of writing provided an unnecessary basis of resistance.

I answered each letter. To begin with, I aimed at giving her a chance to ventilate her feelings about her illness, hospitalization, various doctors and nurses, and other people in her life, especially her husband. I tried only to encourage and support her.

One of Mary's very serious problems was obvious early in our work: her extreme dependence and her anger over lack of fulfilment of these needs; her resentment at the self-imposed limitations because of this dependence; and her resulting deep fear of retaliation and rejection—the reaction to these feelings of dependence and resentment. It was striking that every letter contained an apology for not doing well. In an effort to reduce some of the tension shown in these apologies to me and in fears about all her associates, at first I persistently pointed out to her how well she was doing in her work with me. I added that her repeated apologies anticipated criticisms which in fact I had neither made nor felt about her. In this way I tried to show her that just as she anticipated criticism that I had no intention of giving, so she may have anticipated criticism from others when none was given or meant. No doubt in some instances her defensive attitude, the result of anticipated criticism, in turn aroused actual criticism. We also made some effort to relate this anticipation of criticism and rejection to her earlier childhood relationships, especially with her mother.

In contrast to her earlier opposition, Mary now turned enthusiastically to psychotherapy by correspondence. As the work progressed, a more psychoanalytic approach seemed possible, and this I continued. Later I shall present excerpts from our correspondence, to show this aspect of our work.

Our custom is for Mary to mail her letter, to which I reply, enclosing hers. She then returns her old letter with mine when she sends the next one. In this way, I have a file of all her letters and my replies; that is, a complete history of the correspondence.

At present, the work has continued for more than two years, with an interchange of five letters weekly, and a total of more than 800 letters written by patient and therapist.

Course in Therapy

Mary's first sixty letters, written over a period of about four months, chiefly concerned her current life situation, but also contributed other historical data besides the personal history she had brought to the first interview. In them some definite attitudes towards me as her therapist began to emerge.

History

The personal history summary which Mary brought to the first interview follows. It is worthy of note that the patient's formal education ended with her graduation from high school and that, to my knowledge, she had no familiarity with psychiatric literature when she wrote this history.

'My mother was 7 years old when her mother died. She took over household duties, attended school, and helped her father who was partially lame. Her training was puritanical and superstitious. Aunts who guided her were narrow, bigoted, and unreasonably strict. At the age of 22 she married my father, then 32. It was the first and only marriage for both. I was the first child.

'I have vivid memories of toilet training accomplished by drastic measures and had feelings of horror at accidents.

'My favourite parent was father. I loved going on hikes and fishing trips with him and was an eager listener to his stories of gay times as a young man. He welcomed me as an audience. Mother deplored this and was continually disgraced at father's behaviour and language. He gladly accepted her dominance of everything.

'My parents seldom displayed affection for each other or for their children. Full love was there, but the chief way of showing it was in working hard for us. Watching displays of affection between other children and parents was always embarrassing and considered silly. One exception and time of real comfort for me was during illnesses. My succession of ailments was almost uninterrupted. I never learned to approach my mother with personal troubles or confidences or give her any affection in a normal way. Away from home I brought ridicule on myself when visiting girl friends overnight and refusing to undress completely for night clothes.

'Repressed interest in my own body structure was reflected in childish pre-school drawings. Unable to explain them to mother, I was severely punished and paper and pencils were hidden away for a long period of time. They were favourite possessions and I was shamed repeatedly and filled with extreme feelings of guilt.

'My youngest sister provided an audience and outlet for experiments in exhibitionism which brought more punishment on myself. She was my opposite in all respects and I held feelings of resentment because of her favoured position with the family. I hated myself physically during adolescence. New clothing problems were torture. I tried to hide or wear heavy things. I hated even anklets and thin stockings.

'I developed a fanatical love for a woman schoolteacher in the fourth grade, studied with a frenzy, worked on out-of-class projects, and earned straight A's as long as she was my teacher. I dreamed of this friend for years afterwards and the grades returned to low.

'The family maintained an embarrassed hush on all personal matters. I received instruction on menstruation with great emotional upset. Subsequent difficulty with periods was accompanied by such mental depression that medical help was

necessary to establish regular functioning. I hated all ideas of marriage, scorned all acquaintances who were married, and felt only disgust at any birth announcement. There were later friendships with boys, but all ordinary events and pleasures were overshadowed by my mother's suspicion. I was often accused of activities never occurring to my mind.

' I considered my husband and his family ideal in all respects, enjoyed their company, but found long visits to them almost intolerable. I hated sleeping in their home and avoided it. I was unable to explain these feelings or understand them. They always treated me with loving kindness in spite of this. This family was strongly Catholic and influenced me in becoming a convert. I gave this my full co-operation although always feeling awkward in it, and miserable from my own mother's opposition. I was 18 and my husband 22 when married. The first night of our marriage was the most happy time ever experienced and was marked by absence of any sexual intercourse. Desire for this came later and had to be learned. Marriage was very happy in every respect. Liked children but dreaded experience of childbirth and put it off with financial excuses.

' Dates: Married in 1939; tuberculosis in 1940, first child 1944, tuberculosis 1945, 1946. Spent remaining years fighting asthma and tuberculosis. Experienced one more pregnancy in 1950 which resulted in the death of the child and near death for myself.'

I might add a few details that were brought out in the early correspondence. When, a year after her marriage, Mary was found to have tuberculosis, she was given the traditional bed-rest cure in her mother's home for nine months. After tuberculosis again developed within a year after the birth of her first child, she was in and out of tuberculosis hospitals numerous times. In most instances she left the hospital, protesting against the food, the medical treatment, the lack of diversion, and so on, often against medical advice. Likewise she frequently returned to the hospital at her own insistence, declaring she could not stand the conditions at home, especially her relationship with her husband Thomas. During the hospitalizations she had a number of operative procedures, including pneumonectomy, several thoracoplastic procedures, and the necessary revisions.

Current Life Situation

During the first nine months of therapy Mary was in a hospital. After that time she lived at home and did not return to the hospital as a patient.

The three people about whom Mary has written the most and with whom she has felt greatly involved are Thomas, her husband; Dr. Collyer, an attending woman physician during some of her hospitalizations; and Ingrid, her daughter.

Years ago, Mary pleaded with Thomas, ' Love me like a mother '. Thomas responded by earning enough to provide a living and to pay for Mary's numerous medical expenses, at the same time doing the domestic work when she was at home. Nevertheless all her early references to him bristled with indignation and anger. She accused him of being a hypocrite who concealed his selfishness and hostility, and said, ' I am in a position of waiting to get well enough so that I am no longer dependent on him or the hospital'. Or when he visited their daughter in a nearby boarding school, she was furious with him for being ' so selfish '. On the other hand, she would say, ' I know he doesn't hate me—and when I have believed this I have just been too miserable to think well'.

Among the numerous doctors with whom Mary ' cured ' was a woman doctor who herself had had tuberculosis, Dr. Collyer. Until late in the correspondence, Mary constantly referred to this doctor in the most fantastic terms, reminiscent of her schoolgirl ' fanatical love ' for the woman teacher. Even after she had not seen this doctor for some years, she still felt that the doctor was constantly concerned and thinking about her. For instance, hearing of the doctor's marriage, she reasoned that the doctor had had this rumour circulated in the hope of helping Mary to make a better marital adjustment. Mary kept wanting to be like Dr. Collyer and to work for her, and even took up the study of technical books on X-rays, anatomy, and pathology, and meantime she dreamed of buying a house large enough for the doctor to be able to live with her. She tried constantly to act as she felt the doctor wanted her to, and expressed overwhelming feelings of guilt, fear and anxiety at fancied failures, even though the doctor could not know about her behaviour. It is also interesting that the doctor's name duplicated that of the patient's favourite grandmother, and at the same time indicated her grandfather's occupation and the name of the town in which these grandparents lived. That is, paralleling the real names, for the doctor's name of Collyer, the grandparents, Colliers, lived in Collierville, and the grandfather worked as a coal miner. The patient herself tended to regard the doctor as the kind of mother she had never had.

Mary's daughter, who was 7 years old when Mary began therapy, was enrolled in a boarding school near Dr. Collyer's hospital. At the time, Mary resented having the child at home, but neither did she want to visit her at school nor to have her husband visit Ingrid. Early in therapy, Mary began writing to Ingrid, trying to help her with her problems in much the same way that I was attempting to work with Mary. Ingrid was to grow up like Dr. Collyer, and always do whatever the doctor wanted her to do, Mary felt, and once she wrote a note to Dr. Collyer in the form of a will that the physician should have Ingrid, if she, Mary, should die.

One might sum up Mary's attitude toward herself in the early correspondence somewhat as follows. No matter what subject she wrote about, or whether

she expressed love or hate, she always expressed feelings of intense embarrassment and of extreme apology. When her husband was kind to her, she called him hypocritical; she said, 'I would feel better if Thomas would be mean to me when I don't give him any affection'. Often she provoked him into restraining her, slapping her, or otherwise hurting her in his efforts to keep her from doing some such wholly irrational thing as walking out into the rain in her pyjamas. She left the hospital against advice on numerous occasions; she refused to consent to operations when it seemed she was risking her life to do so. She demanded and threatened to leave home or hospital and live by herself, when such a course was impossible. She tried to manoeuvre her husband into taking a lesser paying job for a doctor whom she herself wanted to work for; and she refused to move elsewhere or otherwise assist her husband even when the changes might have led to pay rises or promotions that would have benefited her quite as much as him, or more so.

Early Attitudes Towards the Therapist

In the initial person-to-person interviews Mary had demanded that I help her in her threats to leave her husband, but once the correspondence began a surprising change occurred. She began to display a desire to please in every way. To this end she worked hard and consistently at her writing, professed her love and desire to help and work for me. Instead of the thinly veiled accusations, in our interviews, that I was no help to her, Mary now constantly blamed and criticized herself for not co-operating, for not doing her work well enough. When she consciously withheld thoughts and information, she rationalized it by saying she might offend the therapist, or be misunderstood, or the material was too trivial or embarrassing. She constantly expressed fear of my disapproval.

What she did write about concerned her ailments and her difficulties with her husband. Interestingly, when I would ask her to go into her thoughts about such symptoms as her cough, allergic reactions, weakness of voice, or colds, she would detail them exhaustively, and then at the end announce that she no longer had the symptom. In this early period the patient began to read psycho-analytic literature, even subscribing to a journal. In addition to the correspondence with her daughter, which she modelled on our work, she undertook rather intensive therapy with a fellow-patient, and began to have fantasies of becoming my assistant.

These attitudes show Mary identifying with me in many ways that greatly resembled her identification with the woman doctor and that may have had great importance in her therapeutic work. They also suggest the character of her early relationship to her parents. Clearly, the woman doctor and I represented aggressors with whom she identified herself in her relationship to fellow-patients when she was frightened of us. Second, the patient saw us as doctor-healers, and again there was evidence of her identification with us as healers. Again, the patient knew that Dr. Collyer had recovered from tuberculosis, and she found out that this was true of me also. Once she remarked that learning this had made it much easier for her to work with me because I could understand her. We were 'all in the same boat'. She also discovered that I had written several papers and parts of two books. She then began to look upon our work as a literary effort, more than once suggesting that it should be published. Often she would include verses which she wrote as a result of our work; for example:

> Auntie Catalyst met an analyst,
> Going to the fair.
> Said the analyst to Auntie Catalyst,
> 'Let me show you there.'
> Said Auntie Catalyst to the analyst,
> 'Your motives—are they many?'
> Said the analyst to Auntie Catalyst,
> 'Indeed I haven't any.'

Finally, the patient identified with me as a reader. Reading was as much a part of our work as writing, and as noted above Mary extended her reading from the letters to psychiatric literature. While under the care of Dr. Collyer she had borrowed and read Gray's *Anatomy*.

In the hospital she often acted so as to exhaust herself and then suffered relapses; after such episodes she always apologized profusely, as if she had injured herself deliberately and had derived an illicit pleasure from so doing. She was extremely reticent whenever any sexual matter came out in the correspondence. If therapy was interrupted, she became extremely restless, and usually did something that resulted in an acute illness. She frequently described crying in reaction to our work, although the overt content of the material at the time hardly explained the crying. As she began to profess her love for me, she depreciated her husband more and more and evidently provoked him into hostile behaviour toward her at times.

Thus, Mary's relationship with me was placatory, self-depreciative, secretive, apologetic, embarrassed, reproachful. Her ambivalence was thinly disguised by the isolation of her positive and negative feelings, the former directed towards me and the woman doctor, the latter towards her husband. She tended always to identify with me in one or more of the roles as aggressor, healer, cured patient, writer, reader. And her attitudes towards me exactly duplicated those which she had previously held towards Dr. Collyer.

Elaboration of a Theme With Recovery and Re-enactment of Early Memories

From her 62nd to her 133rd letter, a period of three months, a theme preoccupied Mary that led to her recollecting an early memory, while at the same

time her preoccupation with the theme and her reaction to the substantiated reconstruction served to re-enact the infantile experience in the transference neurosis, thereby demonstrating its existence and nature.

Mary began this exploration with the observation that evidently the onset of some of her physical complaints (usually involving the gastro-intestinal or respiratory tracts) seemed to be correlated with emotionally disturbing situations. In elaborating this theme, she became preoccupied with the bizarre eating habits of other adults and children, and responded with feelings of shock, horror, revulsion, disgust, and guilt. The interest with which she invested this whole topic is illustrated by her account of how a fellow-patient, a Negro woman, had formerly enjoyed eating a mixture of clay, baking powder and gunpowder.

'I have been thinking over about the clay, and recalling my feelings at the time my friend was telling me about the clay and the baking powder and gunpowder. You attribute my interest and sympathy with her to the fact that I must have had some kind of experience with clay which caused some sort of reaction in myself. I was not aware of this being the case, although your comments may apply to something else which I just remembered today. At the time of hearing this woman's story I was most interested and shocked at her story about gunpowder and its results. I felt that this would surely leave a lasting effect upon her, and knowing that baking powder has some similar ingredients, it might have added to her trouble which came later. The clay by comparison did not sound quite so harmful, but I was wishing that I knew something about all of these things. When people acquire a taste for something of this nature, I have always thought that their bodies must be lacking in some particular element which is not being supplied by the conventional diet.

'I have never had any unusual eating habits, but I knew some people who did. When I was very small I had a playmate that I spent a lot of time with. After she moved away from our neighbourhood, my grandmother took me to her home to visit. The little girl was not present on this particular visit and we were with her mother in the living-room. At this time I heard a story of how little Marie was such a worry because she loved to eat laundry starch and the habit was so persistent that punishment did no good, and it was necessary to hide the box and to keep the child from eating the starch. It was the kind that comes in lumps. The idea sounded terrible to me. It must have made a deep impression upon me because I still remember this house that we visited, which side of the street it was on, and how the outside looked as well as the inside of the living-room. I was there only one time. I could not imagine how anyone could ever enjoy eating something like starch, and in large amounts. I can hardly stand the feel of magnesia in my mouth. I dislike anything that is not food.

'In regard to the little girl who liked eating dirt, it seems to me to be another case like eating starch, but worse because of the filth and danger of disease from eating it. There is a certain amount of animal appetite in all of us, too, I believe, that can come to the fore when there are no inhibitions or other reasons for restraint. Perhaps when an individual eats dirt or clay or starch in the forms I have mentioned, they are being like a dog who eats grass, or cattle who like salt blocks, monkeys who dig salt grains from their fur and eat it. There are different sensations of pleasure that may be satisfied and there is some question about the actual necessity or need for it . . . why do pigs like to lie in mud or why do people like to smoke tobacco? In the case of cattle and salt blocks there is a recognized need for it. Perhaps there are other needs of animals and people that are not understood, and when some unusual behaviour shows up, it is not condoned because of its irregularity.

'I have read that infants can do a good job of picking out a suitable diet for themselves if given a full choice of food and given enough days in which to eventually balance their choices. I believe if we could all grow up from infancy without ever hearing any derogatory remarks about anything, we wouldn't have the strong dislikes that we do for many things, and the bad reactions. I had a cousin who had an unusual craving for brown sugar, just like the child did for laundry starch . . . she always had bags of it and ate it by the handful . . . but no one thought that was disgraceful. I am sure that there are good reasons somewhere for these strange habits.'

Interwoven with her discussion of eating habits were related stories of Mary's cruelty to her little sister and to her cat.

'I have been trying to think of more things to go with the story of Marie and her home. Aside from the appearance of the house and the street, I cannot think of anything directly connected with this, but some other thoughts come to me. When I was about six or seven years old I told my sister to drink some perfume I found at the time, and she did. The feeling that this gave me has always been a vivid memory. The fact that I could so easily get her to do something as wrong as this. I don't know why I thought it was so terrible, but there was a terrible fascination in watching her take a sip of this perfume and wondering what would happen. I don't believe anything happened at all because I don't remember anything more about this. I never had any desire to do such a thing myself.

'The memory made me think of another mean thing that I did one time to a cat. I had a piece of fish which the cat saw and smelled, and I was fascinated over how excited and eager the animal was to get the fish. It was ugly raw fish that my father had left in the cleaning scraps from his fishing. It seemed like an awful thing for any

creature to want, so I tantalized the cat to see how persistent it would be in reaching what it wanted. I spent a long time thinking up one arrangement after another, pitfalls, traps, passage way, and keeping the fish just far enough out of reach so that the cat was frustrated after following along with all my tricks. Eventually the animal went into a fit, and I was *really* fascinated and excited, watching that and feeling terribly guilty to think I had caused such a spectacle. This is all I remember of this. These memories made me start wondering why I had this cruel tendency, and one that seemed to be connected with eating or appetites.'

At first Mary denied memory of any eating problems of her own as a child and she was vague in recognizing any current aversions to food. As the above material was elaborated it became apparent that Mary did have current aversions to greasy foods and to various aromatic substances.

'I like all meat but not the fat; this part of it I can't stand. The feel of it is worse than the taste. I should say that the feel of greasy food in my mouth is a thing that is sickening to me and makes me want to squirm away and run. In eating rich soup that is not hot enough this has often been experienced when the fat rises to the top and consequently it feels the same way in my mouth . . . it is a terrible feeling. I get the same feeling from lipstick and from watching other people use it. The creamy foods in general I am not fond of, although if it has a tart taste as in jello or lemon pie I like it, and chocolate is all right because of the bitterness. . . . The taste and smell of alcohol is always sickening to me except in red wine. I cannot stand the smell or taste of cream of coconut as it comes in candy centres, but I like it in the hard crushed form. I always hate onions, especially the penetrating smell when they are cooking. I like butter because it is salted—not the unsalted. The most disagreeable thing beside the grease in my mouth is the feel of raw egg white. Pasty liver is very much disliked.

'Thomas has the habit of applying polish to his shoes with his fingers. I can hardly stand to watch it. I don't feel like this about handling other materials with my fingers. I don't mind using shoe polish, although I try to keep from breathing in any of the smell. This reminds me of the alcohol which is in hair preparations and other solvents and medicine you have to take at times. It always makes me wrinkle my nose and turn away. But I don't think anyone likes to breathe these things, or do they? I can't remember any eating problems from my childhood. I am extremely sensitive to all drugs and coffee. The cruel tendency comes out now in my playing and joking with people. I can elaborate on this if you wish.'

As work progressed, Mary could recall difficulties over food in her childhood, although she had previously denied having any. Throughout this period of correspondence her repeated references to perfume, baking powder, baking soda, dirt, shoe polish, and grease were notable. Here was a group of traits including a morbid curiosity about eating habits, sadism, aversion to foods, and these traits were constantly mentioned in connexion with one another without any clearly recognizable link between them, and they were invested with a tremendous amount of energy, without demonstrable cause.

As this material was elaborated, and Mary became aware of food aversions and feeding difficulties, they seemed more and more to establish relationships between the various trends: her aversions to specific foods and aromatic substances corresponded with her gastro-intestinal and respiratory reactions to emotionally trying situations; her memories of cruelty involved the use of food and aromatic substances; the bizarre eating habits of others that so interested her paralleled her own problems over specific foods and aromatic substances.

Finally Mary described a memory which concerned her mother's advice to another woman on how to wean a child.

'These memories [of her treatment of the sister and the cat] made me start wondering why I had this cruel tendency, and one that seemed to be connected with eating or appetites. With this subject of cruelty on my mind, I remember the following experience which took place when I was in about the fourth or fifth grade in school. We had some friends who had a baby. The mother was trying to wean the baby from breast feeding and had discussed her problems with my mother. My mother advised her to put black shoe polish on her breast and make it disagreeable for the baby. I overheard them discussing the apparent success of this. I can't describe the shock and horror that I felt. Here the patient's writing became quite uneven with crossed-out words, etc.] Diabolical is the word I would use for these women now. Also today I have realized that it is likely that my mother did this same thing to me. My feelings about this are so violent, I could almost kill someone.'

Shortly after this, the patient wrote cautiously and fearfully to her mother to inquire about her weaning history. Her mother's reply confirmed her suspicions. She had used grease, turpentine, and pancake flour to wean Mary from the breast. Mary's reaction to this news was immediate and violent. She lost her voice, went to bed, and began to complain of abdominal pains, nausea, and vomiting. A fever and leukocytosis also developed and a diagnosis of acute appendicitis was made. Mary refused an appendectomy, demanding that the surgeon call me before she would even consider it. I went to the hospital to see her, and recommended surgery on grounds that appendicitis could not be ruled out, but she refused to consent, and stood firm, despite pressure from doctors, priests, and nurses. Fortunately, she recovered, as all signs

and symptoms soon disappeared. Her appetite then became hearty, and her preoccupation with bizarre eating habits and the related cruelty dropped out completely from her writing.

A week later she wrote:

'I am feeling well again. Yesterday and today Thomas brought some meals from home and I enjoyed them so much. He is going to do this more often. But I believe I may gain some weight now if I continue to enjoy eating as I am now. I had seemed to have my mind bittered up with some ugliness that I couldn't get rid of entirely before now.

'I was recently surprised to find a poem that I recognized as one that I found a long time ago and in a book I had forgotten, but this poem by A. E. Housman intrigued me so that I copied all of it and I have it now in my notebook. It is about the king, Mithridates, who died old, in spite of attempts of enemies to kill him by poisoning. He had so adapted and seasoned himself with all the bitter hardships that life could bring to him that he could not be conquered by any of the things that would have quickly destroyed those around him. When I first read this poem I didn't understand it as well as I do now.

> There was a king reigned in the East;
> There, when kings will sit to feast,
> They get their fill before they think
> With poisoned meat and poisoned drink.
> He gathered all that springs to birth
> From the many-venomed earth;
> First a little, thence to more,
> He sampled all her killing store;
> And easy, smiling, seasoned sound,
> Sate the king when healths went round.
> They put arsenic in his meat
> And stared aghast to watch him eat;
> They poured strychnine in his cup
> And shook to see him drink it up;
> They shook, they stared as white's their shirt;
> Them it was the poison hurt.
> I tell the tale that I heard told.
> Mithridates, he died old.

'The author seems to feel sardonic about the world in general, and in his pessimistic philosophy is advising his friend to take heed of the lessons he can teach owing to his bitter experiences, and to acquire such a tough shield for his feelings that he will be able to endure the greatest hardships. Drowning one's trouble in ale is pleasant but not lasting. His advice to prepare for the very worst and so not be hurt when rough times come is reasonable enough, believing as he does that he must justify God's ways to man, and that the world is essentially a bad place. He seems to want to strike back at the Almighty. I would hate to have such a warped and hopeless outlook as this, or one that is so uninspiring, which is perhaps a better description. Considering this is such a big job to learn to meet life's problems in a confident way, it would seem unnecessarily sad to have to do this in a spirit of vengeance, and in the belief that hardships are the will of God, and with man accepting no responsibilities at all for the state of the world. But I will have to admit that in some of my most difficult times, my thoughts have not been so free from beligerence—they ran something like—"Toss me another—I dare you just one more—let's see if I can get knocked out." I'm not sure whom I was addressing, just everything in general. I suppose this is why I enjoyed the story about King Mithridates.'

At this point I went on vacation. Thereupon Mary, against medical advice, left the hospital and went home and remained there from that time on. Within a month the correspondence was resumed.

The concurrence of the revived memories, the confirmation by her mother's letter, and Mary's physical complaints all suggested a relationship between these factors.

These early memories provide a model for a genetic explanation of the association of the various traits whose concurrence was noted above. On the basis of the weaning experience which Mary discovered (and which had a pattern that typified the mother's relationship to Mary), one would expect to see in Mary mistrust for others, with strong oral sadistic tendencies or defences against these traits. And this was clearly to be demonstrated in the transference neurosis. During this period of correspondence, the patient was obviously trying to please the therapist, but later correspondence showed that the apparently positive transference covered tremendously aggressive and suspicious attitudes towards the therapist. For example, Mary's active attempt to do psychotherapy with a fellow-patient was clearly an acting out of several fantasies at the same time: one of assisting me and the other of taking over my function as a therapist.

I believe that such identifications and other defences in the transference neurosis led Mary to recover the memories described. The lack of transference gratification resulted in a regression, along the lines suggested by the revived memory, which served the purpose of displacing her sadistic impulses from the therapist to the memory and at the same time enabled her acceptably to make further disguised demands on the transference relationship. This was shown, for instance, in her manœuvring the therapist to pay her a hospital visit that certainly did not serve her ostensible request, because she still refused permission for the appendectomy. Her physical reaction, too, may have served the double purpose of a disguised reproach, and at the same time it amounted to turning inward the aggressive impulses that might otherwise have been directed towards the therapist. In connexion with the memory and a corresponding situation in the patient's transference reaction, Mary's attack of appendicitis seems to have been a true reliving of her earlier experience.

A Long Period of Preparation for Things to Come

Following the recollection of her weaning experience, Mary began to eat more adequately, and for the first time for years she began to gain weight. Her attitude towards therapy began to change in the sense that she seemed to take a more spontaneous interest in analysing her dreams and examining her motivations.

Now her self-depreciative and self-destructive tendencies emerged clearly in the therapeutic situation as well as in her past and present life. She left the hospital against medical advice while I was away on vacation; she repeatedly asserted that she was going to stop writing; and she became extremely provocative toward Dr. Collyer, the woman doctor, to whom she made urgent telephone calls. In bitter arguments with her husband she would drive him into violent upheavals, and then become extremely remorseful and self-depreciative. She began to recognize: 'I would be in a bad condition if I couldn't occupy my time in writing or dreaming'; and she became intensely interested in 'how to determine when I am running away from myself'.

As these problems confronted her, the next two hundred letters dealt constantly with the demonstrably active part that she herself played in the development of her own misfortunes. Her self-destructive tendencies were reproaches and at the same time thinly disguised demands which left her weak and helpless. Examination of her behaviour and fantasies showed her that she was constantly trying to avoid feelings of helplessness by attempts at reversal in her fantasies and in some of her actions. Her libidinal and hostile impulses terrified her greatly, especially the fact that she felt both towards the one person as object. She attempted to handle this to some extent by directing her positive feelings towards those at a distance, namely toward Dr. Collyer and me, thus trying to avoid as much as possible the inevitable feelings of anger and frustration toward anyone with whom she had close contact, such as her husband or daughter. Whatever anger and frustration she did feel toward the woman doctor and me, she seemed to take out on her husband, but when the feelings became too intense she would act out in such a way as to try to get away from them. For instance, when her anger towards her husband rose to an intolerable pitch, she would start manoeuvring to get into a hospital, or would walk out of the house, or become extremely ill.

This constant juggling of her feelings and fantasies had to be examined time and again. For example, without apparent reason the patient's letters might show an extremely servile attitude towards the woman doctor, and intensified desires to take care of her, work for her, be like her. Simultaneously Mary would become extremely hostile towards her husband. Further examination of these feelings might lead to such signs of extreme anxiety as wheezing, coughing, sleeplessness, changes in the drainage of her wounds, and dangers of urgent hospitalization. Next, would come her conclusions: that her husband had homosexual tendencies; that the woman doctor was homosexual; and that she herself was homosexual. Finally, it would emerge that she had been extremely suspicious or angry with me; and the whole series of reactions then seemed, at least in part, defensive manœuvres against these feelings in the transference. It was necessary to show her how her fear of all these feelings led her into behaviour that harmed her.

Thus, exactly as her various impulses toward the woman doctor and her husband invariably led into fantasy, identifications, reversals, and destructive acting out, so the same series of events could be observed in the transference reactions. The patient described in her history great anxiety and attempts to suppress or avoid curiosity, exhibitionism, masturbation, cruelty; she related the need for such measures to her mother's intolerance and disapproval of the derivatives of these drives. Similar impulses now, especially towards the therapist, invariably evoked the same prohibitive measures which she assumed that I demanded. It was demonstrated to her that she herself constantly imposed these restrictions upon herself, and that she did so in accordance with her childhood conceptions about her mother's expectations.

'Pink-Pig—Ship Dream'

Exactly on the anniversary of the day correspondence had begun, the patient described a dream. First she spoke of her 'love':

'It makes me want to spend the rest of my life doing something to show my thanks. . . . In view of all this it is certainly annoying and frustrating to have my dream work play such tricks on me as it has been doing recently. We know that you have been represented by little boys and by the colour blue in my dreams. Now after puzzling over the colour pink in a couple of dreams, I see that this must be a new disguise for you. I feel that I have reached the ultimate in disguises when I dream that I came on the deck of a big ship and am introduced to a very nice-looking pig, one that is pink all over. Its legs are unusually handsome and longer than those of other pigs, and its nose is not the proper shape for this animal either and makes me think of Thomas's nose. After this I see a smaller pig in the distance, and it is grey and not outstanding in any way.'

At the end of the dream Mary described

'a small grey craft built differently from all the others. It seems to be built for speed and for some serious purpose, such as a battleship. It moves past everything else with such speed that I exclaim over it, because it seems impossible for any kind of a ship to move like this through the water. I wonder what

is making it work and if it has something other than ordinary engines. With its disappearance in the distance this dream is ended.'

In her associations about pink, Mary expressed considerable confusion as to which colour stood for her and which for me, pink or blue, finally concluding that pink stood for her. The fast-moving ship stood for her in her impatience to get somewhere, she felt, and the pig might also stand for her ' wanting to dominate everything '.

Several days later she added,

' I forgot to put down one detail of the ship dream. In the last part of it, the person with me was pointing to a special structure of some kind in the distance. The bottom of it was blocked from view, but I was told that there were really wheels on the bottom of it, in spite of the fact that it was just another ordinary-looking small boat or building which belonged there near the water or in it. I got the impression that it was important for some reason, or was something other than what it appeared to be. This sounds like something that you have said to me which I have been unable to see.'

There was no more mention of this dream at this time.

For another six months Mary's tendency to avoid situations which might cause her to feel helpless or inadequate or might arouse libidinal or hostile impulses was analysed, as well as her attempts at control when they did arise. There was also more emphasis on the action of these mechanisms as they appeared in therapy.

Suddenly, six months after the above dream (and exactly a year after her recovery of the weaning experience), Mary wrote:

' Yesterday I discovered a page in an autograph book which solves the mystery of the pigs in my dreams. While you were away [vacation] two such dreams occurred, and since the last one left me with no doubts that it stood for you, I could no longer rest without doing some work. I had to know why I would associate you with such a thing as a pig. You probably remember the old dream of my meeting the pink pig on board the ship. After all this time I see that it stood for you then, too. So the other day I decided that the explanation was in a verse that often ran through my head—although this was not a complete explanation. The words are " I love you little, I love you big, I love you like a little pig."

' In one of my recent dreams there was a mother pig lying on her side, and several babies who needed to be fed but were unable to nurse because the nipples of the mother had been heavily coated with something greasy, resembling vaseline. It seemed that my mother had done this and I was standing in her kitchen talking to her feeling so angry I could hardly talk—saying that she knew that was the wrong thing to do, it was bad for the babies, and I was scolding her in the severest way. I felt so outraged as I looked at the pigs. They had no colour except perhaps grey, but the most outstanding thing about them was their strange appearance. The two or three little ones as well as the mother were like very delicate bodies of creatures not even well developed enough to be born. They were soft, not moving at all, had thin transparent skins, and were certainly a sad-looking sight. I picked up one little one to put it close to its mother, but it was no use. The possibility of nursing which they needed to keep them alive had been ruined (my mother may stand for you here, going on your recent vacation). My mother made no response at all in this dream, and that is all of it.'

The patient then described her reactions to my recent vacation—anger, disappointment, determination to terminate therapy. Her associations to the two dreams brought up her feelings of anger and disappointment at age $3\frac{1}{2}$ when she saw her mother nurse her little sister; she then first developed trouble with a draining ear (it lasted for thirty years and stopped when she developed a draining chest), which gradually required her mother to turn all attention from baby sister to herself.

Another group of associations to pig began with ' three little pigs ', included ' butchering ', ' baby pig in a fire ', ' suckling pigs ', and closed with ' big bad wolf after little pigs '. She ended the letter with, ' I can't go on. I guess the last one is it. I'm sorry. I feel awful,' but her next few letters returned to the theme. The butchering idea led to thoughts that she would like to beat her father to a pulp, a dream of holding a big butcher knife over her head to frighten men away, and a conclusion that this is her attitude towards all men—that she wants to frighten them away.

After numerous other associations, she finally concluded that she had been afraid of being both a pig and a wolf.

' Thinking over such a parade of doings, all done with a disguise that looked innocent, or so I must have hoped . . . is enough to make me curl up and die now. Disguises, such as the little pig, which has been removed bit by bit recently and which has caused such terrible sadness and crying as I did it for you . . . because I felt that here I was losing you, because you could not possibly have any respect for me now or like me at all. I felt that there would be no more pleasure for me anywhere, with everything gone.'

Several days later she adds:

' In continuing with my work Friday, with the associations to the pig and the wolf, I only want to add that after my surprise over the discovery of this interpretation, or rather my embarrassment, I decided that I have no reason to feel disturbed and that this was probably what you were expecting. So I am glad it is cleared up now. Woof! '

Having uncovered this fear, the patient now seemed ready to continue the theme about men and boys which had started with her associations to pink pigs and wolves. In high school she had been called ' Woofus ' and this name had appeared in the senior year-book under her favourite song, ' Comin' through the Rye '. When she at last recalled the words of the song she had once memorized, she became extremely mortified, declaring she had never been consciously aware of the meaning of the words.

' First I will tell you the line of the song. The last line is " Yet all the lads they smile on me, when comin' through the rye ". I had remembered it with very little changing. You ask me to tell you what it means to me. The song in its entirety means something like this: If you happen to meet someone you like as you go along, and give them a little loving, what's the harm in that? Every girl claims her favourite boy, and in my case the choice seems to have been still unmade.'

Thus the ' pink-pig—ship ' dream occurred after a long period of analysing Mary's self-destructive and self-restrictive tendencies in both her past and present life and in the therapeutic situation. At first the patient dismissed it with hardly an association, but six months later she took out one element, namely the pink pig, and exhaustively analysed the meaning of this dream symbol to her. In the process she revived some earlier memories and analysed the elements primarily in reference to me, the therapist. Two themes develop, one dealing with who is the pig, Mary or I, and the other with whom pink stands for, herself or me. Her associations finally led her to realize her fear that she was piggish, devouring, and demanding; the awareness of this fear brought some relief, and she could then take up the other theme, after first describing her anger, fear, and avoidance of men. Facing her fears that she might be a pig and a wolf apparently enabled her to face her interest and curiosity in men and boys, although still with considerable embarrassment.

It is interesting also to note that the manifest dream was presented in two parts. One contained the reference to ' pink pig '; the other, which she appended several days later, referred to the ' special structure ' with the ' bottom blocked from view ' and ' wheels on the bottom of it ', said ' to be very important for some reason '. The second part was not mentioned again. It is obvious that the first part has oral features (pig) and phallic aspects (pink) as well. It is highly probable, although we have no associations from Mary, that the second part of the dream referring to underparts and wheels more clearly refers to phallic impulses. Considering that she omitted the second part in her initial report of the dream, we might assume a strong resistance to analysing phallic tendencies, which are acted out in forgetting. On that basis, her telling the first part and forgetting the more purely phallic aspect of the dream parallels and indeed anticipates her associations to the first part of the dream, as they explore exhaustively the oral components (pig) and come to an embarrassed halt when thoughts of pink lead her to realize her curiosity and interest in men and boys. Thus she came twice to an impasse: once in her narration of the dream and once in her associations to it, and each time the obstacle involved phallic aspects. For Mary, this obstacle contained a dangerous subject.

A Dangerous Subject

Although her associations to the pig-ship dream clearly showed Mary relating fears and feelings to me, my counterpart from the past was not so clear. Moreover, the theme of her interest in men and boys seemed much too threatening to Mary. As soon as she had brought it to the surface, she pushed it down and reverted to her old patterns of secretiveness, displacement of her feelings upon some distant figure like the woman doctor, self-disparagement, and so on.

Then she suddenly learned that Dr. Collyer had moved from the hospital where Mary had known her, and Mary reacted to this as a loss of contact that further disturbed her. The resulting defensive immobilization, accompanied by a clearly growing tension, flared up into an intense expression of anger and suspiciousness toward me. She accused me of having something to do with Dr. Collyer's moving and of concealing it; she denounced me bitterly for not answering personal questions. Her oculist maintained two separate offices, one in the same building where I had my office. She bitterly accused me of trying to shunt her from this office to the one some distance away. These expressions of anger and disappointment terrified Mary, and she began to take steps which could have led to her hospitalization. At the same time she visited the fellow-patient on whom she had tried out psychotherapy and arranged to begin treatment by correspondence. I interpreted these moves as attempts to reverse the doctor-patient relationship and thus gain control, and continued the interpretation of these defensive manœuvres for several weeks.

Perhaps in response to my interpretations, Mary stopped trying to be hospitalized again and to do psychotherapy by correspondence with the other patient. She then reported a dream that took her several days to express:

' I have been worrying so much that I am tired out from it now and not capable of doing any very good thinking at all. All I want to know is how you are feeling and if you are all right. I have been like this since I wrote my angry letter to Dr. Collyer. I could do a lot of writing now describing a terrible dream from Saturday night. But it is only a record dream, like a tragic drama of what has happened. No direct harm came to me or to you in the dream, but everything else was blasted out of existence.

This happened so close to us that my only thought was like a pleading cried out over and over and over again, like " no, please . . . not us, please . . . not here, please ". It was like witnessing a bombing raid and being untouched while almost in the midst of it. That afternoon I had been thinking of how a child feels when his parents quarrel or ruin his home . . . no one but the child knows what the feeling is . . . it has to be experienced to know it. It is like any other great experience. True understanding of it is not reached by any amount of effort in mere observation. Now I know what the feeling is. This late in life I have learned this. . . . The thing I probably worry about is having bad thoughts run away with me. It is not that I think they are bad, except in the event that they do run away with me. But perhaps that is what I really wish for and so that is what I have to fear. . . . I had the miserable feeling of being torn in half . . . of feeling helpless to do anything about it. I couldn't do anything about it. Something had to happen, something done by someone else, something as terrible and shattering as was depicted in my dream from last Saturday night to bring about this change in me. Now there will never again be the worry and the fear and the torment from the impossible situation of loving and wanting and needing two different people at the same time . . . a grown-up child still needing its father and mother and unable to rest completely anywhere because as an adult such loyalties are hard to combine.'

Along with this report, Mary described physical collapse, fever, cough, changes in her chest drainage, and frantic visits to her chest physician. She continued:

' In that dream there seemed to be three people sitting on a tiny island and feeling the vast ocean stretched out before them. They were watching a beautiful sunset. This I think is one of the wonderful experiences which people who love each other can share together with such happiness. With the lowering of the sun all other colours in the sky were changing so that with each minute there was a whole new lovely picture to see. Two of the people in the dream seemed to be girls or women, and the other a man. Just as the sun sank below the horizon and it was time for the night . . . the day being completed . . . there was a terrible explosion heard, which shook even the onlooker (myself), standing in the background. Then in looking out into the ocean I could see some huge structures—fine-looking buildings, all spread out in the distance, and all partly completed. Then there were more explosions, one following another, and with each one I saw one of these structures crumble and disappear. This was terrifying to watch because with each one I felt that I might be the next one to be blasted away. Then I was aware of holding a small child in my arms while watching all this, and my fear was for both of us. The remaining details of this dream I have already described in a previous letter to you. I believe I am one of the three on the island . . . you and Dr. Collyer being the other two people. Also I believe the onlooker represents me . . . accompanied by you. I put this dream down today in order to complete my writing about my relationship with two doctors as parents and how changes have come about, and how my present feelings can be explained. Now if I should go about grieving or exhibiting anger, indicating that I still want my mother and father, indicating that I resent any attempt to have either one or the other favoured (I have taken the liberty of considering myself as a child that is wanted, which is phantasy based on more phantasy) . . . if I therefore reveal my true feelings to anyone other than you, and if you reveal to anyone else any indication of some important changes in my feelings, there would automatically be something like this as I see it: " What has happened to Mary, and all her clammering for Dr. Collyer? " '

She went on to describe, in tones of mortal terror, her fears that everyone would conclude that her no longer ' clammering ' for Dr. Collyer meant she had turned to me, and this would inevitably lead to my being ruined professionally because of Dr. Collyer's jealousy and envy.

Subsequent letters have concerned further associations to this dream; further expressions of great fear that this would all end disastrously for me; and finally a recollection of early feelings of devotion and fear toward her father, associated with dread of her mother's disapproval. She recalled that on a fishing trip her father threw a small snake into the fire, and she watched this with terror, feeling that if her father could do this to a helpless little snake, he could also do it to her.

I think that Mary's own words best express the meaning of this dream and its possible significance:

' The three people on the island might be my mother and father, with me, before my sister came. The explosions—with the complete shattering of everything which may have been my world—all this would be what I experienced upon finding that my mother had become a traitor to me—I did not expect nor want this new thing to happen. It came as a surprise. Now actually I remember some of the things in connexion with the discovery of my sister's arrival. But none of the memories are anything connected with the baby. I only remember that I can look back to a certain day, and upon this day I first knew I had a sister. I remember arriving from home after being away for some time—probably at my grandmother's. I came into the house. I believe I was happy and excited . . . things at home have always seemed new after I had been away awhile but I am pretty sure that my family had not moved into this place while I was away. Still I have the feeling of noticing everything as though this might be some affectionate greeting from my mother—I found her in the front room. She seemed very glad

to see me. It seems that she may even have hugged and kissed me. But I remember nothing else, except that I think I walked through the house—the rooms were in a row—with the kitchen last. In the kitchen I took special note of the cabinet—one with high glass doors. I remember the fancy paper pasted on them—exactly how it looked and which side of the kitchen it was on. In this cabinet my father always kept a sack of salted peanuts, upon which he helped himself from time to time. I had some too sometimes. Then I went outside to the back yard. This is all I remember.

'What could there be about this memory which causes it to remain and come to my mind as often as it has in the past—and usually when I think of my sister? Why would I pay attention to parts of the house at this time—not a single thing outstanding in any of this to explain its importance. And as for my sister, I do not have a single memory of her at all when she was a baby, or very young. But I definitely know what day it was that I came home and found out about her. I'm sure my mother would not have told me about her ahead of her arrival. My mother was not like this. But regardless of this it seems likely that her coming would have been a shock to my feelings, I having been the only child. I do know that when later I do have memories of my sister, they were memories of doing something mean to her. Such things that my hate for her must have been tremendous.' [Mary describes provoking her sister into mischief, telling on her, and then, when the parents were punishing her sister, standing in the background watching and listening.]

'If my jealousy caused a severe reaction in my childhood—one which made me feel that my mother no longer meant what she had meant to me before—then this would be like my experience with Dr. Collyer. There I felt that she had done something bad—something which changed my life—something that made me turn to you. I wonder if my looking at the cabinet and thinking of my father and his peanuts was a way of comforting myself at this early time? I wonder if this is when I began turning to him so exclusively? The woman with the child in the dream might stand for the time when I was her *only* one (or his).'

I would add to Mary's analysis only that the dream may also refer to the primal scene. Oedipal material, obviously coloured with oral attitudes, is rising to the fore.

An Interchange of Letters

The following excerpts from a series of letters illustrate both the character of some of the therapeutic interventions and the patient's reactions to them.

After the patient's terrifying dream of the three persons on an island, she began to express great terror that the therapist's work with her gravely endangered him. She wrote:

'I don't know whether this would be of much concern to Dr. Collyer or not. If I should be so foolish or perhaps so ungrateful as to treat her badly or in a different way, it would undoubtedly bring criticism upon you. If perchance some plans of hers would be upset there would be resentment. Since there are no such plans evident, especially in connexion with me, neither would any criticism or resentment be open or direct. There would only be incidents, all coincidence, just as everything else appears to be, and if something affected you unfavourably you would have no defence. Nevertheless, I would feel that *I* am the one who caused you to be hurt . . . I feel all right now and I don't feel so afraid any more. I feel that everything will be all right because I feel in control. I think this is a new feeling which I have never before had in my life. The fear and illness which it has caused was due to the amount of responsibility which was suddenly thrown upon me. It was too staggering for a while and I could only think of the consequences if I failed. You would indeed be hurt . . . there would be hurt everywhere but for you most of all . . . you ask in what ways. In almost every way that a person could possibly be hurt. You might as well be annihilated outright. This was too much for me to contemplate.'

My questions about what caused her to feel such alarm over my safety met with only vague, evasive answers. The patient was really struggling with fears arising out of a dim awareness of her own libidinal and aggressive impulses, and trying to overcome them by attributing them not to herself but to me. This helped temporarily to diminish her own fears and self-reproach, but aroused fears that I would be the victim, instead of her. She then tried to avoid the whole problem by changing the subject and consciously withholding some of her feelings and thoughts.

In this instance she wrote:

'Sometimes I purposely leave out comments which I would not be able to explain at the time because of wanting to cover so much—and I do not want you to misunderstand any of it.'

She goes on to say that if she puts down some of her thoughts I would get the erroneous impression that she was angry, and remarks 'so it may be better that I do edit'. She expresses further fear about my being in danger with respect to Dr. Collyer and concludes by remarking that she feels that it is time for her to stop her work, that it would be best for me to do so.

I replied:

'In this letter you give your rationalizations for weeding out and conclude, "So it may be better that I do edit". If you withhold information or description of feelings and thoughts in order to avoid "misunderstanding", how can we possibly come to an understanding of vital information that

we don't know? How can a jigsaw puzzle be put together when a lot of the pieces are held under the table? You are afraid that I will misunderstand, that I will think you are angry. If I should misunderstand or think you are angry, why should that cause you to be afraid and to avoid it at the expense of your therapy? With whom has misunderstanding and anger brought the pain which you anticipate from me? You still seem to fear that I am in some danger from Dr. Collyer, or that you are in some danger. What do you feel the danger is? How is it that you feel it would help me for you to stop your therapy? I wonder if there is a part of you that feels it might help *you* to stop?'

The patient responded by an extremely evasive introduction, talking about some ideas for educational films, etc. But finally at the end of her letter she commented on a fantasied visit to Dr. Collyer:

'The way I behave then is going to be extremely important to you. I expect to give honest answers, not show any sign of resentment about anything, and act as normal as possible. I can be very good at acting when I have had enough time to bury my feelings. Otherwise I might take off someone's head, and that would not be wise. As long as I can stay well enough to stay out of hospitals, I have nothing to fear. That is the one big way that I could be hurt, to land in the hospital and be forced to do some things that I don't want to do. Here I am relatively free and no one can touch me. But you are not so isolated. When the doctors hear that we are still working together and I appear to be contented, after saying that I wanted and needed so much from other doctors, it spells only one thing. I am getting all the satisfaction I need from you. Then the wheels will start turning if they have not already; and when one person wants to hurt another, they choose the thing that can hurt the most. Just as the most important thing to a patient is his medical care and hospital, the most important thing to most doctors is their practice. And here we are not dealing with ordinary grudges; even those are handled by Dr. Collyer with a relentless vengeance which I have been shocked to witness. When the attack was not on me I forgave it, but it implanted fear and caution in me. Now I must make you realize that we are dealing with a force that is unreasoning. It seeks no reward for itself other than the joy of vengeance. I *know* this. Every effort of yours to gain recognition will be surrounded by danger. It is *awful* for me to think about and I feel like holding my arms around you and telling you not to make a move. If you do believe me, I know this is going to create tension, but that is better than to not tell you. Imagine how I feel, being the cause of all this and of the other outlandish things that have taken place. We must accept it as a challenge and go ahead, but *what* an outlook! And it will not work for you to try to calm and mislead me with other questions. I am calm now, and you need have no concern about that. I will keep trying to write as you wish.'

At this point I thought it might be helpful to structure the problem for the patient at some length:

'In your letter of January 10, as in the last few weeks, you have been expressing a tremendous fear and have attributed it to the possibility that I might be in danger as you saw it. I have been trying to understand this fear and these thoughts have come to me as a tentative explanation. I wonder how they strike you?

'We have been working during the last few months to understand your fears about having wishes and daydreams, and writing about them in our work. This finally resulted in the dream about you and two other people on the island and the terrible explosions, and after this you became very fearful of my safety. Now with the freeing up of the inhibitions to your thinking, your thoughts have turned more towards me and they have been expressed as wanting things from me, etc. They have been further expressed in the form of expressions of love or desire, as manifested by your speaking of love, sweets, kisses, etc., in your letters.

'Now with the emergence of some of these wishes, I wonder if there is a revival of old feelings that you are doing something wrong. You remember when you were going with Thomas, you felt signs of disapproval from your mother with what you described as veiled accusations about sexual activity, etc., although you described yourself as being innocent. Also it would seem that there might be something dangerous in having daydreams of loving or wanting, as suggested by your memory of your father's handling of the snake. If these thoughts have any validity, we might then speculate that in having thoughts about me, there is a fear that I might respond, and that you would then be in danger of criticism on the one hand, and on the other in danger of something from me.

'Carrying the analysis a little further, it would seem that the dreams and the fantasies that you are having about me now are bringing in their wake the same fears of criticism and danger that you felt in childhood, and because of the fear of criticism and danger, there is a need to prevent yourself from having such thoughts, not only with your father when you were a child, but with the boys when you were older, with all men, and now we see it in connexion with me. This time you visualize the danger as coming from Dr. Collyer. We have seen before that in many ways you have regarded Dr. Collyer as a substitute for your mother, and just as you felt criticism from your mother, you now expect the same from Dr. Collyer. But there is nothing that has been *done* that would warrant such criticism, nor do you need have any fear that you will be taken up on any of your thoughts and feelings that you express to me. I will not act upon them. That is understood.'

Mary's answer ignored this letter except for a couple of sentences:

'On the basis of your letter, I would have to decide that I have been mistaken on practically everything I have talked about regarding the doctor and her relationship to me, or that I must simply keep on remembering that you do not write about the things that you are actually thinking. . . . The only fear that I have had is of what you would really think of me in loving you and wanting you as I do and in writing the foolish things that I do. They are to cover up the serious things that I have not had the courage to say.'

I then pointed out that, aside from the above sentences, 'it would appear from your notes in this letter that you would prefer to ignore my letter speculating on your fear that I might act rather than analyse, that you would rather consider it as reassurance than explanatory. It would appear that you have a preference for not analysing these fears but rather a preference for accepting them at their face value.'

The patient replied with some notes in the same vein as her previous ones, but the same day wrote a second letter which she rushed off to me with a great sense of urgency:

'I have to tell you what is wrong. I can't stay like this any longer. To-night after mailing your letter I have felt so awful that I want to die. It is myself that I am feeling so afraid of. I feel so guilty it is horrible. . . . The misery and the doubt in my own strength has made me feel forced to get away from it by projecting it on to you—and now it has come out. . . . I am feeling sick and crying so much this evening for my cowardice that I would rather be dead than go on thinking about having done this to you. If you have thought well of me before, then you would not think so now. No one could take such criticism and such meanness as I have given you . . . my fear has not been about you but about me. I have been driven to such madness of desire for you that I must have looked for something to give it some ease. . . .

'I always have felt that you might be surely disgusted or chased away if I wrote the thoughts I was really having about myself. I had to try to pretend I was too "proper" or too "good" or too "exceptional" to have such wishes or to speak of them. When you have told me and told me I could write whatever I wanted to—yet I have not. I *want* to cheat. I want to do anything that makes me feel good—I would devise any kind of excuses if I could manage to love you directly.

'Right now I am taking up more additional time of yours—while you are being good enough to ask practically no pay. And all the time, deep inside of me, I am wishing and hoping and speculating and feeling like a criminal because of my intentions. I've told you about loving and wanting you but that is not the same as saying that I would go to any length to have you. I have been doing just this. I will have to stop it now, or certainly tell you what I am doing—so you will not be so deceived. . . .

'It is so hard to say to one's doctor—even without facing him—that I want to break every rule that exists—I want to forget everything that is decent. To talk as though you would ever allow me to do this shows how insane I am. It brings me to the status of an animal, and for a person with so much pride, it *would* take a long time to admit what I am. Will talking about it change it? This is what you have taught would help. You have said to "look for the realization of *some* of your dreams—no one can realize *all* of them". Yet I do not listen or care—I want and behave as though it must be *all* of them—using no reasoning. I *have* to be sensible, somehow, but how? I don't want only part of them. I don't want substitutes. . . . Have you wasted all your time because of me and my failure to listen to you? I'm begging you to help me—and all it amounts to is asking you to take me away—desert my family—let me marry you—anything to love you more. Now I wonder if I haven't finally reached the point that *you* were bringing out several days ago. That letter would take care of anything I have said in this letter. "How I have nothing to fear because you would never respond to my feelings." This must mean that I either do not believe you—or else I am angry for your saying you would not respond.

'Now I can see what it is—I *am* angry. I knew it on the day that your letter made me feel so depressed. You *did* understand so well . . . and I have done so much to avoid agreeing with you.

'All that I need to tell you about are the feelings and thoughts that poured through my head after reading that letter. There was no stopping them—after awhile I managed to redirect their force so I didn't recognize them—but not in time for me to forget. . . . It was just like being forced to say to myself: "That settles that. Now it is finished. I can look for some new interests, since I feel deserted now." Then I called up friends. I felt detached and empty and lost. . . .

'I guess this is all now. I feel horrified at myself. I am managing to look at myself now but it is still so hard that it is just like having to look out at a landscape through a tiny little hole in a screen. To observe it more freely would be unbearable to the eyes. I wanted you to be just like me, to grab me, but I didn't want to be reminded that you wouldn't. . . .'

I wrote to the patient:

'In your last letter you describe feelings of desire and love, and these feelings seem to you to be ones that no one would tolerate. Feeling this way, you attempt to avoid or prevent such feelings by skirting around them, focusing your attention on other subjects, etc. But having done this, you feel that you have deceived, and this causes you to feel guilty and

afraid of rejection, which is the very thing that you were trying to avoid. Under what circumstances, experiences, or with what feelings could you have developed such fear of wanting and loving? How was it that you developed this particular method of avoiding or preventing these feelings?'

The patient responded:

'Your letter asks where or how I developed the fear that acts to repress my feelings when I am experiencing such wishes as those expressed in my letter of January 19. You ask how it was that I developed this particular method of avoiding or preventing these feelings. By this time, in looking back at everything, I seem to find only one answer.

'Everything points to my mother, and my fear of her, and when these fears show up in my dreams they take the form of a train roaring towards me, or a cyclone, or explosions, or something of that nature, something so terrifying that it equals the fear that my mother put into me by her punishment. I have not written about any kind of punishment that would fully explain this, because I am unable to remember it. Only those punishments which were very unusual come out in my dreams. But I know whatever other restraint my mother would put upon me, she would certainly accompany it with a severe beating. I know enough of those and when they were administered to leave no question about their being given to me when she was most anxious to have me remember my wrongdoing. Her warning was always, "I'll blister you," or "I'll skin you alive." Afterwards—I could never enjoy freedom without guilty conscience, and if I let myself be punished in my thoughts the punishment would be appropriate to the things I was doing to bring it on.'

This exchange of letters, I believe, illustrates for the reader the nature of my interventions and the patient's responses. As the excerpts illustrate, my interpretations were interpretations of form primarily; when interpretations of content were made, these were quite general. This deliberate pattern was based on the considerations that there was a time interval between my making an interpretation and the patient's reading it; and so I could not always rely on being prepared to make specific content interpretations based upon a clear knowledge of the patient's thoughts and feelings, and to check myself by her immediate associations. Thus the patient herself was obliged to make her own content interpretations.

Current Status of Treatment

At the present time therapy continues along the lines outlined above. It consists of intensive working through in which the dynamics of Mary's behaviour and feelings in the transference neurosis and in other current situations are analysed and related to one another and to her past.

Much more needs to be understood about Mary's regression associated with the discovery of her illness with tuberculosis in 1940. To what extent and in what ways was this a function of the physical illness on the one hand and of psychic conflict coincident with her marriage on the other? As was noted earlier in this paper, Mary was very reticent in her references to masturbation, genital sexual feelings, and related fantasies. Thinly disguised associations to these topics, appearing now, are related to the transference neurosis and require further analysis.

Therapy is being continued by letter writing. I believe that Mary could now tolerate the physical and psychological strains of face-to-face therapy, and indeed she herself in recent letters suggested such a change. Notwithstanding these considerations Mary is making progress in treatment conducted by letter writing and I see no indications for change at the present time, especially when it would involve considerable time and financial problems. These difficulties would, I think, offset any advantages which the more direct face-to-face therapy would achieve at present.

Although much work remains to be done, Mary's very important gains so far, as detailed in the next two sections, show how much has been accomplished by letter writing.

Outward Changes Occurring During Therapy

Many changes took place in Mary's life during the first two years of therapy by letter writing. I do not attribute all these changes to therapy, but it may well have caused some and may help to explain others.

When Mary began therapy her physician considered her almost moribund; she had symptoms of coughing, wheezing, haemorrhage, insomnia, palpitations, anorexia, and inability to gain weight. She had a long record of leaving hospital or home against medical advice. Her actions constantly jeopardized her health. Her relationship with her husband was all but intolerable, and she refused to have anything to do with her daughter, literally evicting her and keeping her away from home.

By the end of two years of therapy she had been at home more than a year, and her acting out had considerably diminished. The sputum had become negative for tubercle bacilli. She had gained weight, and her voice improved noticeably. The coughing, wheezing, and other symptoms had decreased. She had become more understanding and tolerant of her husband. She enjoyed having her daughter at home during the recent Christmas vacation, and felt rather sad on the girl's return to boarding school. The patient had given up her unrealistic attachment to the woman doctor, and could regard the other doctors and her husband in a more matter-of-fact way, rather than as the ogres which she formerly needed to picture them as being.

Discussion

This paper has dealt with an experiment in psychotherapy by written correspondence. The patient had a serious organic disease, with physical disabilities requiring her hospitalization. Our correspondence revealed that by her own actions she was jeopardizing any chances for cure, perhaps to the point of endangering her life. She could hardly tolerate her husband, who from her own description appeared to be loyal, kind, and devoted. She could not stand her 7-year-old daughter. Her illusionary attachment to a woman doctor and fantasies about this woman helped to prevent her from adjusting herself more realistically to life. None of these observations made sense when viewed in isolation or in connexion with one another.

When the patient was enabled to explore her fantasies and her memories, it was disclosed that she had had similar experiences and attitudes in her past. Her lifelong series of ailments had begun, in particular, when she was about $3\frac{1}{2}$, the time of her sister's birth. She loathed her little sister, as she later loathed her daughter (and herself). She herself had played an important and seemingly irrational part in the development of her ailments. She had had, according to her own words, a fantastic attachment to a woman teacher, corresponding with her current attachment to her woman doctor. She had shown signs of cruelty in childhood towards her sister and pet cat in much the same way that she felt her mother treated her, and also as she treated herself, her husband, and her daughter. She had feared and distrusted her father, and felt that both her mother and father drove her to this feeling, which was now repeated toward the woman doctor and Thomas, her husband, the substitutes for her parents.

As therapy progressed, all of these childhood difficulties were expressed again and again, with the therapist substituted for now one person and now another. She greatly desired to please the therapist and feared destruction when she felt she had not pleased him. She conducted a raging battle with all her impulses, apparently in order to avoid displeasing the therapist. Her defences centred chiefly around identification, denial by fantasy, acting out, displacement, somatization, and regression. As these defences were analysed, some of the old fears recurred and then subsided, and new fears developed that required an intensification of her defensive processes. When these were analysed in their turn, it appeared that the patient had become fearful of her erotic fantasies about the therapist, and these fears could be traced back to the fantasies and associated fears that she had had toward her father and mother. Gradually she came to understand these fantasies; they no longer seemed to have the same dreadful meaning for her; some of the defences were dropped in therapy and to a less extent with her husband and child. The woman doctor was no longer required as a substitute for an angry mother, and regressions into illness seemed less imperative. With this came a general improvement in her physical and social status.

Thus in psychotherapy by written correspondence it has been possible to uncover the patient's attitudes in the present and in the past. The patient developed the identical attitudes toward the therapist that she had described as having had towards mother, father, and sister in the past. As she experienced these in the transference neurosis, her memories of the past became more vivid, and previously forgotten experiences and fantasies were brought into consciousness, thereby making possible a more exhaustive understanding of the historical antecedents of her present illness.

In the transference neurosis, it was possible to identify her various defences and the impulses towards which they were directed. The most prominent impulses and those first uncovered seemed to be mainly oral in character. As the transference neurosis developed, it appeared that added to the oral fixations was a negative oedipal complex (e.g. as manifested in feelings for the woman doctor) and regressions to oral modes of action and reaction as defences against a positive oedipal complex. As these defences were analysed the patient's libidinal cathexes became more object-directed and some genital strivings became apparent in the transference neurosis. With the diminution of the counter-cathexis which she was expending in her defensive actions, the patient's physical health improved, as did her social relationships.

Thus it appears that the correspondence therapy brought to light genetic, dynamic, and economic factors; unconscious fantasies and memories became conscious; and some dynamic, economic, and structural changes occurred.

The excerpts from the interchanged letters are given to illustrate my technique and the patient's responsiveness to it. The above discussion has indicated some of the considerations that may account for the patient's reaction to psychotherapy; they are based on the assumption that she reacted to the interpretations and that psychic conflicts were reduced.

Other considerations, however, may have been of importance in her responses.

She apparently identified herself with the therapist as a healer, 'cured' tuberculosis patient, writer, reader. In this way, apparently, Mary found in her therapist a potent narcissistic object choice as well as an anaclitic one. In other words, here was a situation in which the therapist served the function of an ego-ideal and showed Mary that recovery was possible and how it could be achieved. Competition with this ego-ideal may have spurred Mary on to progress.

Furthermore, Mary had fantasies of uniqueness to the point of thinking that I would write a novel about her. This suggests her ideas of returning to a state of bliss like her happiness when there was no little sister. That is, she may have improved in

good measure as a result of her fantasy that she was the therapist's favourite and most interesting patient. Her compliance in writing (and her guilt) may have been a function of this feeling. Throughout her work she mentions wanting to do things for the therapist (producing). These ideas may refer to a pre-sister stage. Around the age of 3, children often do things for their parents, and not out of a wish for autonomous feeling. Her compliance may thus represent a restitutive effort and an attempt not to take responsibility for her own feelings. Her draining chest and her voice impairment may have had the same conflictual introjective and projective significance with respect to Dr. Collyer and me that the draining ear once had had with respect to her mother.

Conducting therapy by correspondence in this case presented both advantages and disadvantages. The chief difficulties centred around the necessary interval of delay between letters. Almost always, two or three days intervened between the patient's description of an affect-laden reaction and her receipt of my reply. Furthermore it was somewhat like working in the dark, in the sense that the patient's absence made it difficult for the therapist to pick up cues so important in therapy, such as facial grimaces, tone of voice, posture, attention, and to guide himself by the patient's associations. For these reasons treatment by letter writing is more subject to misunderstanding than is treatment by direct personal communication. In addition to these obstacles, therapy by letters encouraged the patient to think of herself as working before two audiences, comparable to what a patient in regular therapy might feel if he knew that his associations were being tape-recorded. Not only did Mary express hope that I would write a novel or biography about her, but the most casual inspection of her letters arouses the suspicion that they were written with an audience in mind besides the therapist, and from this source came her self-consciousness of creating something. There is another tendency, I think an inevitable one in correspondence therapy. In ordinary therapy thoughts and feelings are described by vocalization. Secondary elaboration is unavoidable in vocalization, but writing by its very nature, almost by definition, cannot fail to have a greater degree of secondary elaboration. Anyone who has had his spoken words recorded and then written out has been horrified by the relative lack of organization and coherence. In the instance of Mary's letters, there can be no doubt that her thoughts and feelings were subjected to great distortion, as shown by careful grammar, syntax, spelling, and organization.

I am sure that the patient did use all of these limitations in the service of resistance. Therefore I would agree with Grotjahn's statement:

'It depends upon the patient's resistance how much the patient can accept of such interpretation, and there lies the great hindrance of correspondence, and the limitation of it.' Because of these considerations, I would also agree with Rangell, who supervised by correspondence the parental handling of a 7-year-old boy with nightmares. Rangell comments on the problems of correspondence therapy: 'It would be well to reaffirm the obvious dangers involved and the need for caution with regard to the method, long-distance correspondence, which of necessity had to be used in this particular clinical instance. It is indeed the rare situation in which circumstances would all conspire . . . to make this feasible . . . . In the more usual situations which we meet in our everyday practices, it would be unthinkable to consider carrying on through this thin and insecure line of contact.'

On the positive side of the account, therapy for this patient, at least for a considerable period, would have been impossible under other circumstances. Her serious illness and her weak voice precluded the possibility of the usual interview type of therapy. Putting aside these factors, I suspect that the usual type of psychotherapy would still have been impossible for Mary because of her extreme hostility and her overwhelming fear of it. Until recent months it was impossible for the patient to have any sort of person-to-person relationship without being overwhelmed by extreme hostility, guilt, fears of rejection, and masochistic acting out. Throughout the entire period of her therapy, Mary was able to maintain what she regarded as a fairly safe positive attitude with only two persons, the therapist and another physician with whom the patient had no current contact. This attitude of course served the purpose of covering up her underlying hostility and fears, but it also enabled her to maintain what was for her a necessary distance from the therapist while she was trying to face some of her problems.

As for the letter writing, it may well have other dynamic meanings. For instance, the patient was evidently fixated on a narcissistic level, with little object libido. She could invest a tremendous amount of libido in her writing. In away it amounts to projecting herself upon the writing, a desirable choice when compared with the closer face-to-face therapy, where she might have felt far more acutely threatened with fantasies involving introjection of the therapist or damage to him by projection. For example, this oral sadism might have been expressed in fantasy, in terms of the danger from person-to-person interviews, of communicating tuberculosis to the therapist. These considerations may be important also in explaining the different attitudes the patient showed in her face-to-face interviews and in her writing.

One further consideration may have importance. Every psychiatrist and analyst has probably had the experience of a patient bringing written material about his history, dreams, feelings. Dynamically such presentations may be interpreted as gifts, although then are frequently interpreted as resist-

ance. But they may have another significance. In the child's early years, parents often prohibit by speech the child's spoken words and acts. During these early years the child has not learned to write, and therefore writing (or reading), without having been subjected to parental prohibitions in early childhood, is in some instances relatively free of superego restrictions. For instance, although Mary described severe punishments suffered for all types of behaviour, and although her history emphasized her mother's punishments for drawings, nevertheless she stated in her letters that her father always encouraged her artistic or graphic communications. Apparently her mother's admonitions against drawings did not apply to writing, for throughout childhood and adulthood her writing of poems and satirical character sketches earned the amusement and awed admiration of her entire family, including her mother, and it seems to have been the least inhibited of Mary's activities. These considerations, if valid, would help to explain the paradox of the patient's writing things that she resists saying; and this device might therefore in suitable cases have some broader application in psychotherapy and psycho-analysis.

For Mary, writing and reading had perhaps a special meaning. Throughout the later stages of her illness with tuberculosis, Mary showed not only self-destructive tendencies, but also a marked determination to survive. This I think is suggested by her actual survival, despite an extremely poor prognosis and several major operative procedures. In psychotherapy this determination manifested itself as a partial motivation, at least, for the intense efforts which she applied to her letter writing. The written word itself has a survival significance in the sense that it carries with it the meaning of immortality. That Mary felt this comes out in her letters, as in her remark: 'Take these miserable words of mine and publish them. That is all I am good for. That is all I live for.'

On the basis of one case I am reluctant to speculate about possible indications and contraindications for psychotherapy by correspondence. However, in Mary's case, several factors stood out in the decision to try this approach and in her responsiveness to it. No other form of psychotherapy was physically possible because of her illness, hospitalization, voice impairment. Her initial lack of verbal communicativeness, mixed with resentment, and the character of her hostility would have severely hindered the close relationship of face-to-face therapy. Her determination to get well, the relative freedom from superego restrictions, in writing, the ability to libidinize her writing, its survival significance for her and the relative absence of other object cathexes, the free time and inclination to invest energy in her writing—these all contributed to help her respond to this type of psychotherapy. Perhaps the absence of any one condition might have brought a less successful result.

Conclusion

The use of letter writing as a means of communication in psycho-analytic psychotherapy presents many difficulties and limitations, and therefore letter writing is certainly not the method of choice in any case where person-to-person communication is possible. Nevertheless, the experience in this case suggests that a psycho-analytic type of psychotherapy can be accomplished, using correspondence as a medium; and that for some patients under certain circumstances it may have an advantage over the usual face-to-face interviews.

Postscript

After this paper was submitted for publication, and early in the fifth year of therapy (which continued along the lines outlined in this paper), Mary died of congestive heart failure. An autopsy report indicated that 'she had a tuberculous empyema of the right chest with multiple tuberculous lesions scattered throughout her left chest. She had a Gaffky 10 sputum. Next to the pulmonary condition, the most marked thing found at the autopsy was a marked cor pulmonale due to the right ventricular strain imposed by her left pulmonary fibrosis.'

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DISCUSSION

CONTENTS:

FACTS, COINCIDENCE, AND THE PSI HYPOTHESIS
by Charles Brenner

COMMENTS ON DR. BRENNER'S
'FACTS, COINCIDENCE, AND THE PSI HYPOTHESIS'
by Jule Eisenbud

A COMMENT ON E. SERVADIO'S
'A PRESUMPTIVE TELEPATHIC-PRECOGNITIVE DREAM DURING ANALYSIS'
by David Brunswick

REPLY TO DR. DAVID BRUNSWICK'S COMMENT
by Emilio Servadio

FACTS, COINCIDENCE, AND THE PSI HYPOTHESIS

By

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In the past decade there have been numerous articles recommending the usefulness and appropriateness of analysts' assuming that it is possible to have unconscious knowledge of future events (psi hypothesis). Some of these articles have appeared in reputable and widely circulated psycho-analytic journals. As yet no word has appeared in print to question this proposal that what used to be called 'occult' be adopted by psycho-analysts as part of their working armamentarium of scientific hypotheses. Lest this silence appear to express consent, it is proposed in the present article to discuss certain practical and methodological problems involved in the application of the psi hypothesis to psycho-analytic therapy and theory. As an example for discussion, a recent article (Eisenbud, 1955) has been chosen in which an account is given of a clinical experience with an analytic patient which its author considered to be an instance of unconscious foreknowledge. The author treated the incident as such in his therapeutic work with the patient and published it as a paradigm of the value or usefulness in analytic practice of assuming that such foreknowledge does exist.

As a preface to consideration of the validity of this proposal one may consider first of all on what basis the author concluded that he was dealing with a psi phenomenon. In order to do this it will be necessary to review the pertinent facts on which his conclusion was based. These are as follows.

We are told that the patient awoke early one morning 'with a strange feeling of certainty that when he went out to the park he would somehow see a strange bird called the worm-eating warbler. He recalled nothing definite by way of dreams, and was not sure but that this feeling was not part of a dream he had had just as he awoke.' The patient was said to be 'a highly expert, semi-professional ornithologist and bird-watcher' whose knowledge of the habits of the bird in question 'almost excluded the possibility' that he would in fact see the bird in the park that day as he was so sure of doing. Nevertheless, the patient went to the park and within a few minutes did see the bird. Moreover, his observation was confirmed by fellow bird-watchers, as evidence that he did indeed see the bird he had expected to see.

The following facts concerning the bird's habits are adduced to explain why it was virtually impossible that the patient might expect to see a worm-eating warbler in Central Park, New York, on the morning when he did see it.

'. . . the worm-eating warbler, a very distinctive bird with well-known habits, was to be seen in New York's Central Park on only one or rarely two consecutive days a year as it stopped briefly during the course of its annual seasonal migration from South America to its nesting grounds in New Jersey. Some years it would not appear at all. Usually only one or at the most two of these birds would be reported seen on these days and then nothing more would be seen of them until the following year, when again several of the many bird-watchers who haunt the park would notify the Linnaean or the Audubon Society that it had been observed during its annual stopover in New York. What made it almost a certainty that the patient would not see the worm-eating warbler if he prowled about the park on this day is that its annual visit had been observed and duly reported by several bird-watchers almost two weeks before. Never had it been known to make a second visit during the season.'

On the basis of the facts in the above exposition the author assumed that his patient's expectant certainty that he would see the bird that morning was due to unconscious knowledge of a future event (psi phenomenon). The reasoning which led him to this conclusion may be summarized as follows.

1. The probability that a worm-eating warbler would appear in Central Park that morning was extremely remote: 'Never had it been known to make a second visit during the season.'

2. The probability of *that* patient feeling sure he would see the bird was also extremely remote, since as 'a highly expert, semi-professional ornithologist and bird-watcher', who was aware that the bird had been reported less than two weeks before, he *knew* how unlikely it was that the bird might appear in the park a second time.

3. The probability of 1 and 2 occurring *together* was consequently so remote as to make it implausible that they did so merely on the basis of chance.

4. Just such phenomena can be explained on a non-chance basis by the psi hypothesis, whose validity 'has been demonstrated over and over again under the most stringent laboratory conditions during the past eighty years of research in this field'.

5. Therefore the psi hypothesis is the most suitable explanation of the incident related by the patient.

This train of reasoning and the conclusion based upon it may be questioned on two counts. The first count is factual, the second methodological.

As to the first count, the standard reference work for bird-watchers in the New York area is *Birds Around New York City: Where and When to Find Them*, by Allan D. Cruickshank, published in 1942 and sponsored jointly by the American Museum of Natural History and the Linnaean Society of New York. This book gives the following pertinent information concerning the 'Worm-eating Warbler: *Helmitheros vermivorus* (*Gmelin*)'.

The bird's breeding grounds are within 20 miles of Central Park, chiefly to the north, though it also breeds to the east and west of the city. It 'usually arrives on its breeding grounds in a marked wave between 10 and 15 May. A week later the peak of maximum abundance for the entire year is reached. . . . *Stragglers are passing through up to 6 June*' (italics mine). The fall migration begins before the last week in July and continues through September, but 'the southward movement is generally so light that it frequently goes undetected'.

According to Cruickshank, therefore, a bird-watcher in Central Park might expect to see a worm-eating warbler at any time during a period of 21–26 days after it had first been reported in the spring. In addition, he might see the bird on its southward passage at any time between 25 July and 30 September, although his chances of doing so would be distinctly less than in the spring. This is decidedly contradictory to the statements concerning the bird's habits which were given in Eisenbud's article and which formed the basis of his concluding that his patient's reported experience was an example of psi phenomena.

In view of this contradiction it was felt wise to confirm the accuracy of the information in the last two paragraphs by discussion with a competent authority. The one selected was John K. Terres, editor of *Audubon Magazine*, official publication of the National Audubon Society, whose offices are in New York City. The worm-eating warbler was no stranger to Mr. Terres, who promptly and unqualifiedly categorized as incorrect the sentence, 'Never had it been known to make a second visit during a season.' On the contrary, he explained that it might be seen in the park at any of the times indicated by Cruickshank.

If one refers now to the summary of Eisenbud's reasoning given above, it is apparent that

points 1, 2, and 3 are not consonant with fact. Just the contrary, indeed, for

(*a*) the probability that a worm-eating warbler would appear in the park that morning was rather good, since it had first been seen less than two weeks before;
(*b*) the probability that ' a highly expert, semi-professional . . . bird-watcher ' would feel sure of seeing the bird was also rather good, since he presumably *knew* that the chances it would be there were fairly good;
(*c*) the probability of (*a*) and (*b*) occurring together was consequently far from being as remote as the material reported by Eisenbud would have led one to believe.

The importance of checking facts hardly needs to be emphasized. This is a striking example of it. A five-minute telephone call to check the facts reported by the patient in this case would have made clear the unsuitability of this incident for the purpose to which it has been put in lecture and in print, and would in addition have led to a fuller and more accurate understanding of the analytic material. That is to say, assuming, as seems likely, that the patient knew of his analyst's interest in psi phenomena, the incident as reported by the patient, with all its misstatements, whether conscious or unconscious, must have included the expression of important transference wishes if it was not indeed primarily determined by them. For example, the wish to please his analyst, for whatever reasons, might well have been an important, unconscious motive in the patient's mind at the time of the incident which went undetected because of the failure to check facts and the assumption that the incident was an example of psi phenomena.

Now for the question of method. When should a coincidence of event with expectation or dream be considered a psi phenomenon and when a mere chance occurrence? Eisenbud suggests it should be considered the former when the probability of its having occurred by chance is ridiculously or implausibly low. The difficulties with this suggestion are several.

In the first place it is possible to calculate that very many events of everyday life are of an order of probability which must be expressed in numbers that are very small when compared with the numbers which are familiar from everyday use. What is the probability that a given automobile license plate will be seen at a given intersection in downtown New York? The answer is that the probability coefficient would be very small, perhaps of the order of 10^{-6}, a very small number indeed by some standards, but not at all small when compared with the probability of very many, perhaps most of the events of life which we unhesitatingly attribute to chance.

In the second place, it is difficult or impossible to calculate the probability of many events or coincidences by *any* known statistical method. The necessary norms or constants are unavailable. This is particularly and obviously true for *psychic* events like premonitions, a fact which is of special significance for the present discussion.

Indeed it should be apparent that if one insists to begin with on the correctness of the psi hypothesis, and if one consequently makes a habit of having premonitions and predictions about the future or encourages such a habit in one's patients, one will manage often enough to find coincidental facts to reinforce the belief in the hypothesis that one may mistakenly imagine he is *testing*. This is particularly true if one is at the same time ready to disregard whatever facts might dispute or contradict his already fixed conclusion.

In final summary one may repeat the following points.

1. In psycho-analysis, as in any science, facts which can be checked should be checked, particularly before publication in a highly regarded and influential journal with a wide circulation.
2. Useful consequences, e.g. therapeutic ones, may result from checking facts.
3. The application of the laws of probability to many aspects of experience is difficult or even impossible, as when the values of relevant norms and constants are unavailable.
4. By misapplying statistical laws one can make coincidences seem to prove very nearly whatever one wishes to believe, e.g. the psi hypothesis, particularly if one ignores or fails to elicit facts which would contradict such beliefs.
5. It remains to be demonstrated that there is any practical advantage to be gained from the application of the psi hypothesis in psychoanalytic therapy. Attention is called to an important disadvantage that ensued in a published example of such application.

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COMMENTS ON DR. BRENNER'S 'FACTS, COINCIDENCE, AND THE PSI HYPOTHESIS'

By

JULE EISENBUD, M.D., Denver, Colorado

Dr. Brenner has put me on the carpet for not having checked the facts concerning the frequency of appearance of the worm-eating warbler in New York's Central Park. As it happens, the precise data involved, as we shall see, are not too easy to get at. At all events, I was not quite as negligent in the matter as Dr. Brenner charges me with having been.

The episode described in my paper occurred in 1949 and was written up by me at the time almost exactly, save for the introductory and concluding remarks, as it was published. The particular circumstances responsible for the fact that, after some questioning of the patient, I relied on his knowledge and veracity for the details of my account are perhaps not too relevant here. However, before publication, after the lapse of several years, it did occur to me to check the data about the worm-eating warbler as given by my patient. Consulting the literature, I found that this *was* considered a rarely observed (and even more rarely heard) species, and that it was not even catalogued by name in several manuals describing birds commonly found in the north-eastern United States. I next wrote to the National Audubon Society in New York to request data on the actually recorded dates of appearance of the bird in Central Park. I was referred to an ornithologist of the American Museum of Natural History, but from this person I never received a reply to my inquiry. I finally placed my reliance on the description of the bird's habits given in *Birds of America*, T. Gilbert Pearson, Editor-in-Chief (Doubleday, 1936), a standard reference work in the field. 'The worm-eating warbler', it is there stated, 'is not so rare as it has been credited. . . . But the search for him has to be made in ravines and on dry forested hillsides where the undergrowth makes a convenient nesting site.' I did not gather from this that an individual was at all likely to come upon him during a casual stroll in Central Park, whose terrain hardly fits that given in the description of where the bird might turn up.

Now Dr. Brenner has come up with statements by recognized authorities from which he draws inferences which are in radical contradiction to the statements made by my patient concerning the rarity of the worm-eating warbler in New York's Central Park. On this basis he comes to sweeping conclusions as to the validity of my observations and my method.

First as to the facts. Dr. Brenner cites a statement by Cruickshank which, he claims, renders the facts as given by my patient grossly incorrect. But this statement, as is immediately verifiable, concerns the frequency of appearance of the worm-eating warbler in its *breeding* grounds, which are distributed over an area of several hundred square miles. According to every source I have consulted, this bird does *not* breed in New York's Central Park, an area of roughly one square mile. And says Cruickshank (*op. cit.*), 'Wherever the species does not breed in our region it is known only as an astonishingly rare transient visitant.'

Undoubtedly a designation of 'astonishingly rare transient' is still too broad for our purposes, since it does not provide a satisfactory estimate of the chances of a person observing the worm-eating warbler on any given day in Central Park. We should have to depend for this on precise records of the actual dates of the bird's observed appearance in Central Park over a period of years, as well as on data as to the number of specimens counted on every such occasion. Regrettably, Mr. Terres' reported statement—that the worm-eating warbler *might* (not *may*) be seen in Central Park on any of the dates indicated by Cruickshank as the times of the bird's appearance on its breeding grounds—is entirely too ambiguous to be of much use to us. Cruickshank himself does not give the data we want, but states merely that 'Away from the breeding grounds, even in the most favoured localities, a count of more than two on any one day is exceptional.' The assistant librarian of the National Audubon Society, to which I again wrote, was unable to find the records, published

or otherwise, which might help us, but supplied the quotations from Cruickshank given by me above. The only statement I am able to find, finally, relating to the probability of the worm-eating warbler turning up in Central Park on any given day is given by Griscom in *Bird-Hunting in Central Park* (Amer. Mus. Nat. Hist. Guide Leaflet No. 68). ' One can never tell ', says this author, who merely lists our bird as appearing *almost* every year, ' just which ones of the rarer species will appear, or when.'

All in all, I think we may safely conclude that even though my patient, calling upon the empirical lore of Central Park's habitual bird-watchers, may, in a literal sense and in some minor degree, have overstated the case for the rarity of his bird (and this has yet to be substantially demonstrated) he was certainly not far off his mark as far as the fundamental point at issue is concerned. The probability would indeed appear to be quite remote that an individual wandering in an area of one square mile will chance upon one of perhaps two birds which *might* be there under favourable circumstances. In any case, in view of what (corrected) data we have, Dr. Brenner would appear to be pushing his authorities somewhat beyond maximum load, since we can hardly consider the chances of coming upon a worm-eating warbler during a stroll in Central Park on *any* day to be ' rather good ', as he would have it. We may not infer from the proposition that one swallow does not make a summer the fact that two do.

However, let us suppose, for argument's sake, that there may be a somewhat greater warrant than was at first believed for the application to the events described of a particular normal hypothesis. (As Dr. Brenner quite correctly points out, it is impossible precisely to evaluate this with any known statistical method.) By no means would the warrant for the concurrent application of the psi hypothesis be eliminated or even, as far as that goes, appreciably reduced. By way of analogy, let us imagine that a man receives a message from an unknown source stating that a certain rare book can be found at a given book mart. The man goes to this place and within a few minutes comes upon the book in question. He feels extremely grateful to his unknown benefactor, since to the best of his belief there are only two copies of this book in existence. Later he learns that there are actually five—or ten, or twenty, it matters little. It would be quite wrong for him to conclude now that there was no relationship between the message he had received and his discovery of the now only *comparatively* rare book.

The analogy to our case is entirely just if we accept, as I maintain the overall evidence justifies beyond any reasonable doubt, the independently established existence of what is defined as psi awareness in individuals. From here on it is simply a question of evaluating all pertinent data in order to find some basis for inclining toward one or the other of the hypotheses being considered. As is so often the case in situations of this sort, there may be no factor or factors which can crucially resolve the issue, and the hypothetical rôle of psi, as I stated in my paper, ' can perhaps never be decisively settled, what with the nature of the material and the circumstances of its development '.

But neither, for that matter, can the rôle of chance, contrary to Dr. Brenner's ostensible supposition, widely shared in principle by critics of psi and psycho-analysis alike, that when any loophole for chance can be demonstrated in an indeterminate probability situation, chance is *ipso facto* the explanation of choice for whatever is observed to occur.

Dr. Brenner, however, does not rely solely on the chance hypothesis. Employing a gambit which is again a favourite of critics of both psi and psycho-analysis, he offers in addition a ' normal ' deterministic hypothesis to account for what took place on the theory, perhaps, that chance *plus* a thoroughly familiar and inoffensive hypothesis is an unbeatable combination. He suggests that the incident reported by the patient and subsequently by me may have been an expression of, ' if it was not indeed primarily determined by ', important transference wishes, for example, the wish to please me. But surely, if there is such a thing as a latent psi capacity in individuals (and here, it must once again be pointed out, an independently tested and proved hypothesis to this effect is merely being applied to a specific set of events), a patient could just as easily please me, and at the same time have this pointed out to him, by genuinely utilizing this capacity as by going to great lengths, consciously or unconsciously, to make it appear falsely as if this were the case. It is clear, thus, that such a consideration cannot be used as a basis for evaluating the relative merits of the two hypotheses in the present situation.

' It is almost impossible ', says Griscom (*loc. cit.*), ' to get something for nothing. Hunting rare warblers in Central Park is no exception to this rule. . . . The prizes come only to the

energetic and the persistent.' The whole point of the incident reported by me is that my patient awoke one morning with a heavily overdetermined need to prove to himself that one could indeed get something for nothing, that one could magically recapture the rapidly disappearing breast with the power of the wish, and without energy and persistence. Small gratification it would have been to him in these circumstances, it seems to me, to have resorted to the self-deception suggested by Dr. Brenner when, if he really believed that his chances of seeing the worm-eating warbler that morning were very remote (which, all sources considered, they apparently were) he could accomplish his miracle, if only symbolically, by unconsciously calling upon a latent capacity which is theoretically an important life-preserver of the otherwise fairly helpless infant.

Finally as to Dr. Brenner's statement that, 'As yet no word has appeared in print to question the proposal that what used to be called "occult" be adopted by psycho-analysts as part of their working armamentarium of scientific hypotheses.' The fact is that the critical literature on the psi hypothesis as it may be applied in psycho-analytic work dates back almost a quarter of a century, has appeared in several psychiatric and psycho-analytic books and journals (including, not too long ago, this one) seems to be rapidly growing, and, at this stage, should hardly require, with or without field-glasses, too much energy and persistence and certainly no occult powers for its discovery.

A COMMENT ON E. SERVADIO'S 'A PRESUMPTIVE TELEPATHIC-PRECOGNITIVE DREAM DURING ANALYSIS'

By

DAVID BRUNSWICK, Ph.D., Los Angeles

In connexion with E. Servadio's recent paper on 'A Presumptive Telepathic-Precognitive Dream During Analysis' (*Int. J. Psycho-Anal.*, **36**, 1955), I wish to point out a possibility which Professor Servadio does not consider in his printed paper, whether or not he took it into account in reaching his conclusions.

I shall summarize a few facts in the situation under discussion. The patient was to have an analytic hour on the evening of 28 August. This appointment was cancelled by means of a message taken to the patient's flat by the maid of the analyst at five on the afternoon of the 28th. It is not stated that the patient did not see the maid, but it seems to be presumed that he did not. The dream in question is stated to have occurred in the night between 27 and 28 August, and that is how the patient must have reported it in the next following hour, which was on the evening of the 29th.

Now, judging only from what we have been told and not been told, there seems to be a clear possibility that the dream was actually dreamed in the night between the 28th and 29th, with a falsification about the time (conscious or unconscious) on the part of the patient. If it was thus, the precognitive element disappears, since the maid delivered the message on the afternoon of the 28th.

Furthermore, there also seems to exist the possibility that the patient was at home when the maid came to his flat, that therefore he saw her and she delivered the message in person; and finally it is also possible that she imparted to him in a friendly, gossipy way some of the other information that appears in the dream. So, if some of these things were also so, some of the telepathic elements in the dream also vanish.

Now I do not for a moment want to claim that this is the way it was. I merely want to point out that Dr. Servadio did not consider these possibilities in his paper and so did not give factors or evidence to rule them out. I think this should be done, and all the alternative possibilities explored as thoroughly as possible in working in this startling and puzzling realm, which has impressed itself more or less upon many psycho-analysts.

REPLY TO DR. DAVID BRUNSWICK'S COMMENT

By

EMILIO SERVADIO, Rome

Dr. Brunswick's remarks about the paper he quotes seem to me very pertinent. A careful student should always think of any possible way of ruling out supposed 'paranormal' factors in a given occurrence, and see whether the facts could be not interpreted in a 'normal' fashion. This is, of course, what I have constantly tried to do (my general attitude is apparent in the very title of my paper), although perhaps such endeavours can never reach 100 per cent evidence.

Regarding the first point raised by Dr. Brunswick I can only say that my patient (who was, as it will be remembered, an obsessional) was always extremely precise in his statements, and that his memory of details, even after a notable lapse of time, was astonishingly accurate. It seems therefore highly improbable—and this is all I can state—that he should have made such a major mistake about the night of his dream. I fully acknowledge that this is not a certainty in a mathematical or factual sense: it is only a very probable assumption as far as my knowledge of the case goes. In fact, I am still quite confident that no falsification of time did actually occur, although I obviously cannot prove it.

Dr. Brunswick, however, has certainly noticed that in my paper, my opinion regarding the possible precognitive elements in the case was particularly cautious, owing to the great difficulty of making assessments about any alleged precognitive phenomenon. I wrote, in fact, that a couple of items in the occurrence *seemed* to me 'not fully understandable in purely "telepathic" terms', etc.—a wording which to some of my readers appeared almost deprecating.

About the second point of Dr. Brunswick's note I feel much more confident and tranquil. First of all, A. was an English-speaking patient, and my maid N. could not speak a word of English. Apart from this, she would have recoiled at the very idea of having any amount of conversational gossip with one of my patients —particularly with a non-Italian! As a matter of fact, I gave her a *written note*, by which I was informing my patient that his session was cancelled, and she simply handed over my letter to him. The only 'conversation' between the two could not possibly go beyond a couple of *buona sera*, followed by a curt nod on the part of the very restrained and aloof Mr. A. In this occurrence, my maid behaved only and exactly as the faithful carrier of a written message.

In my opinion, therefore, the *telepathic* value of the incident remains in full. I am—and was —less confident about its *precognitive* aspects, and I admit that Dr. Brunswick's remarks about such aspects are justified. I wish to thank him cordially for his interest in my paper, and for his friendly co-operation.

112TH BULLETIN OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION

EDITED BY
RUTH S. EISSLER, M.D., GENERAL SECRETARY

REPORTS FROM THE COMPONENT SOCIETIES

North America	PAGE
American Psychoanalytic Association	58
South America	
Argentine Psychoanalytic Association	61
Brazilian Psychoanalytic Society (Sao Paulo)	62
Chilean Psychoanalytic Society	62
Europe	
Belgian Psycho-Analytical Society	62
British Psycho-Analytical Society	63
Dutch Psycho-Analytical Society	66
French Psycho-Analytical Society	66
German Psycho-Analytical Society	68
Italian Psycho-Analytical Society	69
Swedish Psycho-Analytical Society	70
Swiss Psycho-Analytical Society	70
Vienna Psycho-Analytical Society	70
Asia	
Indian Psycho-Analytical Society	71
Israel Psycho-Analytical Society	72
Sendai Psychoanalytic Society	72

NORTH AMERICA

AMERICAN PSYCHOANALYTIC ASSOCIATION

36 West 44 Street, New York 36, N.Y.

I. *Officers* of the American Psychoanalytic Association, 1953–1955: Ives Hendrick, M.D. (*President*); Maxwell Gitelson, M.D. (*President-Elect*); Richard L. Frank, M.D. (*Secretary*); Robert T. Morse, M.D. (*Treasurer*). They were succeeded on 8 May, 1955, by the following *current officers:* Maxwell Gitelson, M.D. (*President, 1955–1956*); William G. Barrett, M.D. (*President-Elect, 1955–1956*); Douglas D. Bond, M.D. (*Secretary, 1955–1957*); Robert T. Morse, M.D. (*Treasurer, 1955–1957*).

II. *Members of the Executive Council*, 1954–1955: Ex-Officio Voting: Ives Hendrick, M.D. (*President*); Maxwell Gitelson, M.D. (*President-Elect*); Richard L. Frank, M.D. (*Secretary*); Robert T. Morse, M.D. (*Treasurer*); LeRoy M. A. Maeder, M.D. (*Ex-Secretary*). Ex-Officio Non-Voting: M. Ralph Kaufman, M.D.; Robert P. Knight, M.D. Elected Councillors-at-Large: Grete L. Bibring, M.D. (1951–1955); Robert Waelder, Ph.D. (1952–1956); Emanuel Windholz, M.D. (1953–1957); Ralph R. Greenson, M.D. (1954–1958).

III. From May, 1953, to May, 1955, *124* new members were elected to active membership in the American Psychoanalytic Association. In May, 1954, Dr. Ernst Kris was unanimously elected to Honorary Membership. During the two-year period May, 1953–April, 1955, 17 members died.

IV. In May, 1954, three new Institutes were approved by the Board on Professional Standards: (1) Los Angeles Institute for Psychoanalysis; (2) Institute for Psychoanalytic Medicine of Southern California, and (3) Division of Psychoanalytic Education of the State University Medical Center at New York.

Also in May, 1954, the application of the Philadelphia Association for Psychoanalysis to sponsor

a Training Center at the Western Reserve University School of Medicine, Cleveland, Ohio, was approved for a provisional period of three years.

In May, 1955, Affiliate Society status was accorded to a group of members at present working in the Division of Psychoanalytic Education at the State University Medical Center at New York City (Brooklyn, N.Y.).

Also in May, 1955, the New Orleans Psychoanalytic Society was recognized as an Affiliate Society of the American Psychoanalytic Association.

As of May, 1955, the American Psychoanalytic Association numbers 14 Approved Training Institutes, 16 Affiliate Societies, and 3 Training Centers.

V. Miss Anna Freud delivered the Fourth Freud Anniversary Lecture on 'Psychoanalysis and Education' at the New York Academy of Medicine, 5 May, 1954. The following week-end she was one of the participants in a Scientific Program sponsored by the New York Psychoanalytic Institute. On 10 May, 1954, she was guest speaker at two sessions of the Philadelphia Association for Psychoanalysis. At the afternoon session for members and students, she spoke on ' Sources of Analytic Material ' and led the discussion which followed; at the evening session, before a large audience of professionally qualified persons, she gave a lecture on ' Diagnosis and Assessment of Early Childhood Disturbances.'

VI. In May, 1955, the appointment of an Ad Hoc Committee to consider the question of a by-law on qualifications for foreign training was authorized by the Executive Council of the American Psychoanalytic Association.

VII. (1) The Macmillan Company is the authorized sales representative in the United States for the Freud Memorial Volumes, now in the process of publication.

(2) Dr. Leo H. Bartemeier represented the American Psychoanalytic Association at the recent unveiling of the statue of Sigmund Freud at the University of Vienna.

(3) The American Psychoanalytic Association will participate in the raising of funds to purchase the Freud home in London and convert it into a museum as a permanent memorial to Freud.

(4) The centenary of Sigmund Freud's birth will be celebrated at the Annual Meeting of the American Psychoanalytic Association to be held in Chicago 26–29 April, 1956.

Scientific Meetings: Future Meetings: 1955 Midwinter Meeting, 1–4 December, Roosevelt Hotel, New York City. 1956 Annual Meeting, 26–29 April, Hotel Morrison, Chicago.[1] 1956 Midwinter Meeting, 6–9 December, Roosevelt Hotel, New York City.

The 1953 Midwinter Meeting took place in New York City from Friday, 4 December, 1953, to Sunday, 6 December, 1953. The 1954 Annual Meeting was held in St. Louis, Mo., from Friday, 30 April, 1954, to Sunday, 2 May, 1954. The 1954 Midwinter Meeting took place in New York City from Friday, 3 December, 1954, to Sunday, 5 December, 1954.

1955 Annual Meeting, Atlantic City, N.J.

Friday, 6 May, 1955.

Scientific Papers and Brief Communications

Chairman: George S. Goldman, M.D. (New York).

Morning Session:

Scientific Papers, Section I

A. ' Narcissism, the Oral Triad and the Ego-ideal in Psychosomatic Disorders '. Joseph Kepecs, M.D. (Chicago). Discussant: Catherine L. Bacon, M.D. (Philadelphia). B. ' The Management of an Erotized Transference '. Ernest Rappaport, M.D. (Chicago). Discussant : Mabel B. Cohen, M.D. (Chevy Chase, Md.).

Afternoon Session:

Brief Communications (with Discussion)

Barbara Young, M.D. (Baltimore): ' Sleep during the Analysis of an Aggressive Man.' Alexander Grinstein, M.D. (Detroit): ' Comes the Knight in Shining Armor.' Philip Weissman, M.D. (New York): ' On Pregenital Compulsive Phenomena and the Repetition Compulsion.' Paula Elkisch, Ph.D. (Philadelphia): ' The Psychological Significance of the Mirror.' Martin H. Orens, M.D. (New York): ' The Result of Termination of Analysis in a Depression.' Charles Brenner, M.D. (New York): ' A Reformulation of the Psychoanalytic Theory of Parapraxes.' Sanford Gifford, M.D. (Boston): ' Transient Disturbances in Perception: Two Psychoanalytic Observations.' William L. Peltz, M.D. (Philadelphia) : ' Transference in Psychoanalytic Case Supervision.' David Kairys, M.D. (New York): ' Unconscious Mechanisms in a Patient with Hyperventilation Tetany.'

Panel Discussion A. ' Affects, Object Relations and Gastric Secretions.' Chairman: Lawrence Kubie, M.D. (New York). Reporter: George E. Gardner, M.D. (Boston). Presentation: ' The Study of an Infant with a Gastric Fistula.' George L. Engel, M.D., and Franz Reichsman, M.D. (Rochester, N.Y.). Participants: Therese Benedek, M.D. (Chicago), Sibylle Escalona, Ph.D. (New Haven), Roy Grinker, M.D. (Chicago), George Ham, M.D. (Chapel Hill), Sydney Margolin, M.D. (New York), I. Arthur Mirsky, M.D. (Pittsburgh), René Spitz, M.D. (New York), Thomas Szasz, M.D. (Bethesda).

[1] The site of the 1956 Annual Meeting was changed from Dallas, Texas, to Chicago, Illinois, at the Annual Meeting in May, 1955, when the membership unanimously approved the resolution that the American Psychoanalytic Association go on record as being unwilling to hold its convention in any city where discriminatory practices will be encountered.

Scientific Papers, Section II

Morning Session: Chairman: Sarah Tower, M.D. (Baltimore). A. 'The Symbolic Meaning of the Corner.' Samuel Sperling, M.D. (Beverly Hills). Discussant: Morris W. Brody, M.D. (Philadelphia). B. 'Ambivalence.' Morris W. Brody, M.D. (Philadelphia). Discussant: Henry W. Brosin, M.D. (Pittsburgh). C. 'A Contribution to the Study of Instincts.' I. The Erotic Instinct. Mortimer Ostow, M.D. (New York). Discussant: Leonard Sillman, M.D. (New York).

Afternoon Session: Chairman: Helen V. McLean, M.D. (Chicago). D. 'The Concept of Resistance as a Narcissistic Defense.' Paul Sloane, M.D. (Philadelphia). Discussant : Jan Frank, M.D. (New York). E. 'The Ego and the Introjects.' III. Advanced Stages of Splitting in Schizophrenia. Gustav Bychowski, M.D. (New York). Discussant: Gregory Zilboorg, M.D. (New York). F. 'Dreams, Images and Perception' (Slides). Charles Fisher, M.D. (New York). Discussant: Ernst Kris, Ph.D.

Saturday, 7 May, 1955.

Panel Discussion B (Members only). 'Psychoanalytic Curricula—Principles and Structure.' Chairman: Lucia E. Tower, M.D. (Chicago). Reporter: Hans W. Loewald, M.D. (Baltimore). Presentation: 'The Teaching of Therapeutic Psychoanalysis.' Richard L. Frank, M.D. (New York). Participants: Francis McLaughlin, M.D. (Baltimore Psa. Inst.), Grete Bibring, M.D. (Boston Psa. Soc. & Inst., Inc.), John M. Murray, M.D. (Boston Psa. Soc. & Inst., Inc.), Helen V. McLean, M.D. (Chicago Inst. for Psa.), Henriette Klein, M.D. (Columbia Univ. Psa. Clinic), Paul Sloane, M.D. (Inst. of the Phila. Assn. for Psa.), Eugene Pumpian-Mindlin, M.D. (Inst. for Psa. Med. of So. Calif.), Carel Van der Heide, M.D. (Los Angeles Inst. for Psa.), Sara Bonnett, M.D. (New York Psa. Inst.), Otto Isakower, M.D. (New York Psa. Inst.), Morris Brody, M.D. (Philadelphia Psa. Inst.), Sylvan Keiser, M.D. (Psa. Inst. of State Univ. Med. Ctr., N.Y.), Emmy Sylvester, M.D. (San Francisco Psa. Inst.), Otto Fleischmann, Ph.D. (Topeka Inst. for Psa.), Rex Buxton, M.D. (Washington Psa. Inst.), Robert P. Knight, M.D. (Western New England Inst. for Psa.).

Panel Discussion C. 'The Dream in the Practice of Psychoanalysis.' Chairman: Sandor Lorand, M.D. (New York). Reporter: Leo Rangell, M.D. (Beverly Hills). Presentations: A. 'Dreams and Affects.' Samuel A. Guttman, M.D. (Princeton, N.J.). B. 'On "Reading" Manifest Dreams and other Unconscious Material.' Leon J. Saul, M.D. (Media, Pa.). C. 'Transference Phenomena in the Dream.' Edith Weigert, M.D. (Chevy Chase, Md.). Participants: Franz Alexander, M.D. (Chicago), Robert Fliess, M.D. (New York), Ives Hendrick, M.D. (Boston), Milton Miller, M.D. (Beverly Hills), Herman Nunberg, M.D. (New York), Richard Sterba, M.D. (Grosse Pointe, Mich.), Elizabeth Zetzel, M.D. (Cambridge, Mass.).

Panel Discussion D. 'Re-evaluation of the Libido Theory.' Chairman: Robert Waelder, Ph.D. (Philadelphia). Reporter: Charles Brenner, M.D. (New York). Participants: Nathan W. Ackerman, M.D. (New York), Robert C. Bak, M.D. (New York), Frieda Fromm-Reichmann, M.D. (Rockville, Md.), Rudolph M. Loewenstein, M.D. (New York), Karl A. Menninger, M.D. (Topeka).

Morning Presentation. 'Psychoanalytic Instinct Theory and Social Psychiatry.' Alfred Stanton, M.D. (Wellesley Hills, Mass.).

Afternoon Presentation. 'Concepts of Therapy Derivative from the Libido Theory.' Norman Reider, M.D. (San Francisco).

Panel Discussion E.

Morning Session only. 'Factors in the Growth and Development of the Psychotherapist.' Chairman: Adelaide Johnson, M.D. (Rochester, Minn.). Reporter: John Spiegel, M.D. (Boston). Presentation: 'Factors Entering into the Development of a Psychotherapist.' O. Spurgeon English, M.D. (Philadelphia). Participants: Joseph C. Chassell, M.D. (Stockbridge, Mass.), Joan Fleming, M.D. (Chicago), Martin Grotjahn, M.D. (Beverly Hills), Alfred O. Ludwig, M.D. (Boston), Sydney Margolin, M.D. (New York), Herbert S. Ripley, M.D. (Seattle).

Scientific Papers, Section III

Afternoon Session only: Chairman: Maurits Katan, M.D. (Cleveland). 1. Studies in Schizophrenia. A. 'The Significance of Exogenous Traumata in the Genesis of Schizophrenia.' David Robinson, M.D. (Rochester, Minn.). B. 'Observations on Ego Functions in 35 Schizophrenic Patients.' Adelaide M. Johnson, M.D. (Rochester, Minn.). Discussant: James Mann, M.D. (Boston). 2. 'Transient Psychotic Episodes during Psychoanalysis.' May E. Romm, M.D. (Beverly Hills). Discussant: O. Spurgeon English, M.D. (Philadelphia). 3. 'Human Ego Functions in the Light of Animal Behavior.' Edith Weigert, M.D. (Chevy Chase, Md.).

Scientific Papers, Section IV

Morning Session: Chairman: Lewis L. Robbins, M.D. (Topeka). 1. 'On the Theory of Psychoanalytic Treatment.' Thomas Szasz, M.D. (Bethesda). Discussant: Victor Calef, M.D. (San Francisco). 2. 'The Marriage Bond.' Martin H. Stein, M.D. (New York). Discussant: Jacob A. Arlow, M.D. (New York). 3. 'Etiology of Prejudice.' Brian Bird, M.D. (Cleveland). Discussant: Sol W. Ginsburg, M.D. (New York).

Afternoon Session: Chairman: John A. P. Millet, M.D. (New York). 4. 'Informational Value of a Supervisor's Emotional Experiences.' Harold Searles, M.D. (Rockville, Md.). Discussant:

William Murphy, M.D. (Boston). 5. 'Problems in the Study of Changes during and after Psychoanalytic Treatment.' Henriette R. Klein, M.D. (New York). Discussant: Helen H. Tartakoff, M.D. (Cambridge, Mass.). 6. 'Therapeutic Results in Psychoanalytic Treatment without Fee.' Sandor Lorand, M.D. (New York). Discussant: Lawrence Kubie, M.D. (New York).

Sunday, 8 May, 1955.

Scientific Session——Central Fact-gathering Committee

Report 4—Comparative Data from 2,000 Initial and 500 Final Reports of Cases of Anxiety Neurosis, Homosexuality, Passive-Aggressive Character and Schizophrenia. With Slides. Chairman: Harry I. Weinstock, M.D. (Attendance limited to members of the Association and participating senior Candidates.)

Reports on Panels. Chairman: Rudolph Loewenstein, M.D. (New York) and Reporters for Panels A, B, C, D, and E.

SOUTH AMERICA

ARGENTINE PSYCHOANALYTIC ASSOCIATION

(Asociacion Psicoanalitica Argentina)

Anchorena 1357, Buenos Aires, Argentina

Officers (1955): Dr. Luisa G. de Alvarez de Toledo (*President*); Dr. David Liberman (*Secretary*); Dr. Mauricio Abadi (*Treasurer*); Dr. León Grinberg (*Publishing Director*); Dr. Enrique Pichon Riviere (*Director of Institute*).

Training Committee: Dr. Enrique Pichon Riviere (*Director*), Dr. Angel Garma, Dr. Arnaldo Rascovsky.

Training Analysts: Dr. Luisa G. de Alvarez de Toledo, Dr. Celes E. Cárcamo, Dr. Angel Garma, Dr. Marie Langer, Dr. Arminda A. de Pichon Riviere, Dr. Enrique Pichon Riviere, Dr. Enrique Racker, Dr. Arnaldo Rascovsky, Dr. Luis Rascovsky.

Candidates in Training: 21 conducting case work under supervision; 14 in preparatory analysis.

Programme of Courses:

First Year: Dr. Angel Garma: General Theory of Neuroses (25 seminars, 2 terms). Mrs. Matilde Rascovsky and Dr. León Grinberg: Instinctivity (26 seminars, 2 terms). Drs. Arminda A. de Pichon Riviere, Nora R. de Bisi, Alberto Tallaferro: Child Development (2 terms). Dr. Marie Langer: Introduction to Technique (27 seminars, 2 terms). Dr. Mauricio Abadi: Introduction to Psychoanalysis (36 seminars, 2 terms). Dr. Enrique Pichon Riviere: Technique Seminar (13 seminars, 1 term).

Second Year: Drs. Teodoro Schlossberg, Jorge Nöllmann, Juan Carlos Bisi, José Luis Gonzalez, Aniceto Figueras: Freud's Clinical Case Histories (40 seminars, 2 terms). Mr. Willy Baranger: Dreams: Theory and Practice (23 seminars, 2 terms). Dr. David Liberman: Special Theory of Neuroses, Psychoses, Perversions and Characteropathies (26 seminars, 2 terms). Dr. Heinrich Racker: Collective Control of a Case (25 seminars, 2 terms). Elisabeth G. de Garma: Technique of Child Psychoanalysis (10 seminars, 1 term).

Third Year: Dr. Fidias Cesio: Freud's Remaining Writings (27 seminars, 2 terms). Dr. Arnaldo Rascovsky: Collective Control (26 seminars, 2 terms). Dr. Enrique Pichon Riviere: Theory of Technique (28 seminars, 2 terms). Drs. Arminda and Enrique Pichon Riviere, Emilio Rodrigue: Basic Writings of Melanie Klein and her School (31 seminars, 2 terms). Dr. León Grinberg: Applied Psychoanalysis (27 seminars, 2 terms). Dr. David Liberman: Special Theory of Neuroses, Psychoses, Perversions and Characteropathies (25 seminars, 2 terms).

Child Analysis: Mrs. Elisabeth G. de Garma: Technique Seminar (8 seminars, 1 term).

Papers read in the Argentine Psychoanalytic Association:

Dr. Fidias Cesio: 'Psychoanalytic Studies on the Theory of Spiritualism.'

Dr. Angel Garma: 'Vicissitudes of the Dream Screen and of the Isakower Phenomenon.'

Drs. Arminda A. de Pichon Riviere and Luisa G. de Alvarez de Toledo: 'Music and Musical Instruments.'

Dr. Arnaldo Rascovsky: 'On the Genesis and Evolution of Scoptophilic Tendencies.'

Dr. Arminda A. de Pichon Riviere: 'Dentition, Walking and Talking in relation to the Depressive Position.'

Dr. Jorge E. Nöllman: 'Psychoanalytic Considerations on a Delirious System—the Electra Conflict in an Old Lady of 84.'

Dr. Hernando Pastrana Borero: 'Direct Expressions and Elaborations of Masturbatory Fantasies of an Adolescent Girl.'

Mrs. Genevieve T. de Racker: 'On a Specific Type of Anxiety.'

Dr. Salomón Resnik: 'Cotard's Syndrome and Depersonalization.'

Mrs. Madeleine Baranger: 'Illness Fantasy and Insight Development in a Child Analysis.'

Dr. Arnaldo Rascovsky: 'Clarifications of Inner Vision.'

Mr. Willy Baranger: 'Assimilation and Capsuling—Study of the Idealized Objects.'

Mrs. Madeleine Baranger: 'Expulsion and Sublimation, Management of the Internalized Objects (A Dream-Analysis).'

Dr. Diego García Reinoso: 'Construction of a Persecutory Reality.'

Dr. Fidias Cesio: 'A Case of Impotence.'

Dr. Fidias Cesio: 'Two Ulcer Patients.'

Dr. Aniceto Figueras: 'Psychoanalysis Applied to Medicine. Bases for the Integration of Medical

Thought through the Pluridimensional Approach in the Examination of Patients.'

Dr. Arnaldo Rascovsky: 'From Inner Object to Outer Object. Externalization and Internalization. Identification and Pseudo-identification.'

Dr. José Luis Gonzalez: 'Psychoanalytic Contributions to the Study of Colitis.'

Dr. Emilio Rodrigue: 'The Setting of Discovery.'

Dr. Jaime Tomás: 'An Aspect of the Maternal Super Ego and Analytic Evolution in a Character Neurosis.'

Dr. Guillermo Ferrari Hardoy: 'The Psychological Problem of Masturbation.'

Mrs. Genevieve T. de Racker: 'Aspects of the Psychoanalysis of a "Foreigner" (Contribution to the Study of Negative Therapeutic Reaction).'

Mrs. Mathilde Rascovsky: 'Fragment of the Analysis of a Surgeon.'

Mrs. Elisabeth G. de Garma: 'Reaction and Management of Parents in Child Analysis.'

Symposium on Schizophrenia held at the Argentine Psychoanalytic Association: Among the participants were: Drs. Arminda and Enrique Pichon Riviere, Dr. David Liberman, Dr. Emilio Rodrigue, Dr. Nelly Garcia Badaracco, Dr. Albert Tallaferro, Dr. Jorge Mom, Mrs. Marcelle Spira, Dr. León Grinberg, Dr. José Remus Araico, Dr. Diego García Reinoso, Dr. Salomon Resnik, Dr. Edgardo Rolla, Dr. José Luis Gonzalez, Dr. Mauricio Abadi, Dr. Alberto Fontana Lahitte, Dr. Fidias Cesio, Dr. Gino Amici di San Leo and Mr. Willy Baranger.

Lecture-Course for Friends of the Argentine Psychoanalytic Association:

Dr. Luisa G. de Alvarez de Toledo: 'History of Medical Psychology and Psychoanalysis.'

Dr. David Liberman: 'Practical Aspects of Psychoanalysis.'

Dr. Mauricio Abadi: 'Dreams and their Psychoanalytic Interpretation.'

Dr. Arnaldo Rascovsky: 'The Experience of a Sinister Story.'

Dr. Enrique Pichon Riviere: 'Poetic Creation in the Comte de Lautreamont.'

Dr. Angel Garma: 'The Duodenal Ulcer in the Hero of a Book.'

Dr. León Grinberg: 'Migraine in Some Characters in Literature and History.'

Dr. Marie Langer: 'On Some Psychological Aspects of Elizabeth the First of England and Other Women of Her Day.'

Dr. Celes E. Cárcamo: 'Magic Thought.'

Other Activities: Dr. Alberto Tallaferro delivered a course on 'Introduction to Psychoanalysis' for general practitioners.

BRAZILIAN PSYCHOANALYTIC SOCIETY (SAO PAULO)

(*Sociedade Brasiliera de Psicoanalise*)

No report of annual activities received.

CHILEAN PSYCHOANALYTIC SOCIETY

(*Sociedad Chilena de Psicoanalisa*)

Santo Domingo 444, Dep. 1, Santiago de Chile

Officers: Dr. Carlos Whiting (*President*); Dr. Ramón Ganzarain (*Secretary*); Dr. Erika Bondiek (*Business Secretary*).

In 1954 we had a total of 27 students, 17 of whom are medical, and 10 are lay students.

We have been improving our criteria for the selection of candidates, following basically the experience of Hanns Sachs communicated in his paper on the training analysis.

Lectures and Seminars at the Training Institute during 1953 and 1954:

First Year Course: Dr. Carlos Whiting: 'Introduction to Psychoanalysis.' Dr. Ramón Ganzarain: 'Introduction to the Technique.' Prof. Dr. Ignacio Matte: 'Mechanisms of Defense.' Dr. Erika Bondiek: Seminar on Dreams.

Second Year Course: Dr. Ramón Ganzarain and the members of the Training Committee: 'Special Theory of Neuroses.' Dr. Carlos Whiting and Dr. Ramón Ganzarain: Case Seminars.

Third Year Course: Prof. Dr. Ignacio Matte: 'Problems of Metapsychology.' Dr. Arturo Prat: 'Child Analysis.' Dr. Ramón Ganzarain: 'Psychoses.'

Training Committee: Drs. E. Bondiek, R. Ganzarain, I. Matte-Blanco, A. Prat, A. Segovia and C. Whiting.

EUROPE

BELGIAN PSYCHO-ANALYTICAL SOCIETY

(*Association des Psychanalystes de Belgique*)

118 rue Froissart, Brussels, Belgium

Au cours de l'année académique 1954/55, les travaux de training ont continué au rythme précédent. Les étudiants et les membres présentent des études de textes ou des observations cliniques se rapportant entr'autres à la psychothérapie des parents, aux difficultés rencontrées au commencement d'une analyse par les débutants, a l'Oedipe dans la névrose obsessionelle, à la psychosomatique ou a l'étude des oeuvres d'Abraham. Un groupe de travail s'occupe exclusivement de cas cliniques discutés.

Des analystes étrangers nous apportent leur collaboration, par ordre chronologique, les Drs. Lebovici, Diatkine et de Saussure.

23 analyses didactiques sont en cours actuellement, 4 candidats sont en contrôle.

Parmi nos membres se sont inscrits 3 nouveaux candidats, un membre est passé au titre d'adhérent, 2 sont devenus membres titulaires.

Nous avons perdu un de nos membres honoraires, le Dr. Odier.

BRITISH PSYCHO-ANALYTICAL SOCIETY

63, New Cavendish Street, London, W.1

Report for the Year 1953–54

During the academic year 1953–54, the Society has held seventeen Scientific Meetings, including the sixth Ernest Jones Lecture which was open to the public. This lecture was given by Ernst H. Gombrich, M.A., Ph.D., the subject being 'Psycho-Analysis and the History of Art.'

At the first Scientific Meeting of the year, which was held in October 1953, the Society welcomed Dr. David Rapaport from Stockbridge, Massachusetts, U.S.A.

List of Scientific Meetings

Dr. D. Rapaport: 'The Theoretical Structure of Present-day Ego-Psychology.'

Miss H. Sheehan-Dare: 'Homicide During a Schizophrenic Episode.'

Dr. W. H. Gillespie: 'The First International Conference on Para-Psychological Studies held in Utrecht in August.'

Mrs. H. Ries: 'A Character Analysis.'

Dr. C. Anderson: 'Movement, Stasis and Death in Psychic Life.'

The Rev. R. P. Casey: 'Unconscious Factors in Christian Liturgy.'

Dr. W. C. M. Scott: 'A New Hypothesis Concerning the Relationship of Libidinal and Aggressive Instincts.'

Dr. Susannah Davidson: 'Influence of Trauma on Character and Development of a Female Patient.'

Dr. C. F. Rycroft: 'Two Notes on Idealization, Illusion and Disillusion as Normal and Abnormal Psychological Processes.'

Dr. D. W. Winnicott: 'Meta-Psychological and Clinical Aspects of Regression within the Psycho-Analytical Set-up.'

Dr. J. M. Taylor: 'In Search of an Identity. Notes on the History of a Manic-depressive Delinquent.'

Dr. H. M. James: 'A Case of Fetishism.'

Dr. M. Balint: Fun Fairs, Thrills and Regression.'

Dr. K. Frank: 'A Case of Over-Indulgence.'

Miss P. H. M. King: 'A Patient's Use of Dissociated Fantasy Systems as a Defence Against Anxiety Arising During Separation.'

Dr. A. Davidson: 'The Analysis of a Delusion in a Chronic Paranoid Schizophrenic.'

The Associate Members' Group. The Associate Members' Group (Clinical Section, Chairman Dr. A. G. Thompson from June to December 1953, and Dr. S. T. Hayward from January to June 1954) held five meetings.

1953–54 Membership. Active Members 84; Associate Members 81; Total 165.

The 18th International Psycho-Analytical Congress. The Congress held from 26 to 30 July, 1953, at Bedford College, Regent's Park, was a scientific, social and financial success. The Society was host to those attending the Congress at a Reception on 26 July. On 27 July the official Reception was tendered by the London County Council. On the day following the Congress the Royal Medico-Psychological Association arranged a special Course of Lectures by Drs. Bartemeier, Jones, Menninger and Zilboorg.

As the outcome of an informal meeting of members of European Training Committes held in London during the Congress, Drs. Gillespie and Winnicott were asked to become the nucleus of a European Committee whose aim would be in the first place to pool information about experience and methods of training in the various countries. As a preliminary, copies of the British Training Regulations, and where relevant translations into French or German, were sent to the training committees of the European societies and to the Israeli Society. We have received replies from all countries and details of training from four societies: Belgian, French, German and Vienna.

It is intended to circulate the results to all the societies concerned and invite their comments.

Visitors. During the year visitors from the following Societies attended Scientific Meetings: American, Argentinian, Australian, Brazilian, French, Hungarian, Indian, Israel, Swedish. Dr. Hans Aufreiter, Secretary of the Viennese Society, visited London in November and met most of the members of the Council and Training Committee.

Obituary. During the year we have suffered the loss by death of the following members: Dr. K. Stephen on 12 December, 1953, and Dr. D. N. Hardcastle on 17 May, 1954. On 30 May, 1954, Dr. C. P. Oberndorf of New York, who had been associated with the Editorial Board of the Journal continuously since 1921, died.

Branch Society and Sponsored Study Groups

The Australian Society of Psycho-Analysts

Melbourne Institute for Psycho-Analysis. Dr. F. W. Graham reports:

The Australian Society held one meeting at which Dr. Clara Lazar Geroe was re-elected President and Dr. F. W. Graham was elected Secretary-Treasurer. Miss Ivy Bennett of Perth was elected to membership. A four-day conference was held.

Sydney Institute for Psycho-Analysis. Dr. A Peto reports:

Scientific Activities. The following members of the Institute read papers at the Conference of the Society of Australian Psycho-Analysts held in Melbourne from 1–4 December, 1953: Dr. M. Hall, 'A Case of Obsessional Neurosis'; Mrs. J. Nield, 'Analysis of a $2\frac{1}{2}$-year-old Child'; Dr. A. Peto, 'On Depersonalization'.

Dr. A. Peto was a faculty member and group leader of the Seminar on Mental Health in Childhood which was organized by the World Health Organization and by the Commonwealth of Australia, and held in Sydney from 10 to 27 August,

1953. He held two lectures: (1) Psychoanalytic Theory of Early Personality Development; (2) The Effects of Separation on Childhood.

Teaching Activities (Dr. A. Peto). Theoretical Seminar (fortnightly) for members and candidates of the Institute.

Study Group, consisting of members of the Institute and psychiatrists, and reviewing the current psychoanalytical and psychiatric literature. Number of participants: eleven.

Introductory Seminar in co-operation with the Institute of Child Health, University of Sydney, for pediatricians of the Teaching Hospitals. Number of participants: eleven.

The Canadian Society of Psycho-Analysis

Dr. A. W. MacLeod reports:

A. *Changes in Membership.* It is with great pleasure that the Society reports the election of Dr. Hans Aufreiter to active membership. Dr. Aufreiter has been granted permission to reside in Canada and has taken up his appointment at McGill University. Dr. Gottfriede Aufreiter, his wife, is expected to join him by the middle of July, 1954.

B. *Scientific Meetings*

Dr. Bruce Ruddick: 'Slips of the Tongue and Homosexuality.'

Dr. W. C. M. Scott, British Psycho-Analytical Society : 'On the Psychopathology of Disturbances in Time Perception.'

Mme. Francoise Boulanger: 'Study of an Hysterical Lesbian.'

All members participated: 'Problems of Psychoanalytic Technique.'

Dr. Charles Fischer, N.Y. Psychoanalytic Soc. : 'Preconscious and Archaic Modes of Perception in the Formation of Dreams.'

Dr. J. B. Boulanger: 'The Castration Complex in a Case of Male Homosexuality & Fetishism.'

Dr. J. P. Labrecque: 'On Transference & Counter-Transference.'

Dr. D. Lagache, French Psycho-Analytical Soc.: 'Aspects of Transference.'

C. *The Canadian Psychoanalytic Review.* The Canadian Group of Psycho-Analysts has arranged for the publication of its own journal which will carry in full, both in English and French, the text of each scientific paper delivered before the Society. The first issue of the Canadian Psychoanalytic Review will appear towards the end of July, 1954.

D. *Business Meeting.* At the Business Meeting held on 17 October, 1953, the Canadian Society of Psychoanalysts voted to change its name to the Canadian Psychoanalytic Society in preparation for incorporation in the Province of Quebec. The Members of the Society are Members or Associate Members of a Component Society of the International Psycho-Analytical Association. The names of the present Members of the Society are as follows: H. Aufreiter, Francoise Boulanger, J. B. Boulanger (pending election to the French Psycho-Analytic Soc.), J. P. Labrecque, A. W. MacLeod (President), M. Prados, B. Ruddick (Secretary), E. Wittkower, T. Chentrier.

Institute of Psycho-Analysis

Report of the Training Committee as at 30 June, 1954.

Meetings and Attendances. The Training Committee held 14 ordinary meetings during the year: Dr. Scott (Chairman) 14; Dr. Heiman 14; Mrs. Hoffer 14 ; Dr. Lantos 14 ; Dr. Payne 14; Dr. Rycroft (Deputy Secretary) 14; Dr. Winnicott (Secretary) 13.

Students in Training. On 30 June, 1953, there were 60 students in training. Of these 18 finished their training during the year. The number of students in training on 30 June, 1953, was 67.

Post-Graduate. There are 26 students of child analysis: 8 started during the year of whom 2 are associate members and 6 are students. During the year Dr. M. James, Dr. L. Munro and Miss R. Thomas were qualified as child analysts.

Guest Students. During the year the following have attended as guest students from overseas: Dr. Guettler (Sweden); Dr. Linneman (Sweden); Dr. Mendes (Brazil).

The Australian Society of Psycho-Analysts

Melbourne Institute for Psycho-Analysis. During the year 1953–54 three students were in training and two students had one case each. (Report from Dr. Clara Lazar Geroe.)

Sydney Institute of Psycho-Analysis. Two students are under training at the Sydney Institute. One student (medical) has five adult patients, and one child patient. The other student (non-medical) continues her training in child analysis. (Report from Dr. Andrew Peto.)

REPORT FOR THE YEAR 1954–55

The British Psycho-Analytical Society has held eighteen Scientific Meetings during the academic year 1954–55.

The seventh Ernest Jones Lecture was held in March and was given by John Wisdom, Fellow of Trinity College, Cambridge, with the title 'The Logic of the Unconscious,' This lecture was open to the public.

List of Scientific Meetings (1954–55)

Dr. W. C. M. Scott: 'Progress in Psychology, Psychiatry, Psycho-Analysis and Psychiatric Social Work.'

Mrs. E. M. Rosenfeld: 'Notes on Infanticide.'

Dr. M. Balint: Funfairs, Thrills and Regression—Part II.'

Dr. B. Lantos: 'Comments on the Concept of Sublimation.'

Dr. J. L. Rowley: 'The Importuner.'

Mr. M. Masud R. Khan: 'Notes on Homosexual Episodes in a Male Patient.'

Dr. B. Lantos: 'On the Motivation of Human Relationships.'

Dr. H. Racker: On Music.'

Discussion on the *ad hoc* committee's Memorandum on Homosexuality.

Dr. Audrey Davidson: 'Some Aspects of the Analysis of a Depressive Patient.'

Dr. E. Rodrigue: 'Discovery in the Analytical Situation.'

Dr. M. Williams: 'Notes from the Analysis of a Scientist.'

Dr. C. F. Rycroft: 'Symbolism and its Relationship to the Primary and Secondary Processes.'

Mrs. B. Sandford: 'An Obsessional Man's Need to be "Kept"—Part II.'

Miss M. Bavin: 'A Case of Hysterical Bisexuality.'

Dr. A. H. Williams: 'Problems encountered in the Analysis of a Drug Addict.'

Dr. C. Anderson: 'Some Observations from the Analysis of a Horse-Fetishist.'

Dr. D. W. Winnicott: 'Withdrawal and Regression.'

The Clinical Essay Prize for the year 1954 has not been awarded as the papers submitted did not fulfil the requirements.

Branch Societies and Sponsored Study Groups

The Australian Society of Psycho-Analysts

Officers elected for 1955: Chairman: Dr. R. C. Winn. *Secretary:* Dr. A. Peto.

Dr. A. Peto reports:

The Society held its interstate conference on 'Problems of Technique' from 18–20 June, 1954, in Sydney. The following papers were read:

Dr. S. Fink: 'Patients who Complain' (Sydney).

Dr. C. L. Geroe: 'Acting Out' (Melbourne).

Dr. M. Hall: 'A Case of Schizophrenia' (Sydney).

Mrs. J. Nield: 'Enlightenment in Analysis' (Sydney).

Dr. A. Peto: 'Acting Out' (Sydney).

Dr. H. Southwood: 'A Case of Hysteria' (Adelaide).

Dr. R. Rothfield: 'Fetishism' (Melbourne).

Another interstate conference was held from 11–15 January, 1955, in Adelaide. The following papers were read:

Dr. C. L. Geroe: 'Development and Function of the Ego' (Melbourne).

Dr. M. Hall: 'Homosexuality and Schizophrenia' (Sydney).

Dr. A. Peto: 'A Theory of Play' (Sydney).

Dr. R. Rothfield: 'Problems of Technique' (Melbourne).

Dr. H. Southwood: 'Conversion Hysteria' (Adelaide).

Dr. R. C. Winn: 'Some Aspects of Manic-Depression' (Sydney).

Mrs. J. Nield: 'Psychoanalysis of an Adolescent Girl' (Sydney).

Dr. F. W. Graham (Melbourne) and Dr. I. Bennett (Perth) contributed to the discussions.

Sydney Institute for Psycho-Analysis. Dr. A. Peto reports:

Scientific Activities. Apart from the activities mentioned in the report of the Society, Dr. A. Peto participated as a guest-speaker in a Symposium on Juvenile Delinquency, which was organized by the Australasian Association of Psychiatrists.

Teaching Activities. Theoretical Seminar for members and candidates of the Institute.

Study Group consisting of members of the Institute and psychiatrists.

Seminar in co-operation with the Institute of Child Health, University of Sydney, for pediatricians of the Teaching Hospitals.

It is regretted by all members of the British Psycho-Analytical Society that *Dr. Clifford Scott* was not able to remain President for the past year or to stand for the Presidency for the coming year. He had been offered and had accepted the position of Associate Professor in the University of Montreal, with the acknowledged aim of teaching psycho-analysis to students. Dr. Scott is the first psychoanalyst to hold a professorship to teach psychoanalysis in the Commonwealth.

Dr. Sylvia Payne replaced *Dr. Scott* as President in October, 1954.

The Freud Centenary Committee was elected this year by the Society.

In the course of the year the British Psycho-Analytical Society was asked to send a representative to give evidence to the British Medical Association Committee on Hypnotism. Dr. Bion kindly consented to do this and we owe him thanks for the valuable contribution which he made and the time and trouble involved.

We have welcomed visitors from the Indian Society, Heidelberg, San Francisco and Buenos Aires.

4 Members were elected during the year.

15 Associate Members were elected during the year.

3 Members from Budapest were transferred—Dr. and Mrs. Levy, and Miss C. Balkanyi.

The Canadian Psychoanalytic Society was incorporated on 5 January, 1955.

Institute of Psycho-Analysis

Report of the Training Committee as at 27 May, 1955.

Meetings and Attendances. The out-going Committee held one meeting. Twelve ordinary meetings were held during the year by the Training Committee:

Dr. Payne (*Chairman*); Dr. Heimann (*Joint Sec.*); Mrs. Hoffer (*Joint Sec.*); Dr. Lantos; Mr. Money-Kyrle; Dr. Pratt; Dr. Wride.

Training Regulations. The Training Regulations were revised in accordance with the Council's recommendation on 31 May, 1954.

Financial Assistance to Students. During the year new loans amounting to £200 have been granted to two students not previously in receipt of loans.

Students in Training. On 30 June, 1954, there were 67 students in training. Of these 10 finished their training during the year.

List of Lectures and Seminars delivered during the Year ended 30 June, 1955

First Year Course: Lectures on ' The Principles of Psycho-Analysis,' Dr. Hoffer.

Seminars: Dr. Bonnard, Dr. Rycroft; Miss Joseph, Dr. Lantos, Dr. Munro; Mr. Money-Kyrle, Miss Schwarz.

Second Year Course. Lectures on ' Clinical Psycho-Analysis ': (*a*) Perversions and Related Character Disorders, Dr. Gillespie; (*b*) Neuroses, Dr. Foulkes; (*c*) Introduction to more recent developments, Dr. Rosenfeld.

Lectures on ' Child Analysis ': Course A, Mrs. Bick, Mrs. Klein. Course B, Miss Hellman, Miss Schwarz.

Seminars (Adult Case): Dr. Munro, Mrs. Sandford. Course A, Dr. Heimann, Dr. Winnicott. Course B, Mrs. Hoffer.

Third Year Course. Lectures on ' Later Developments in Theory,' Dr. Balint, Dr. Payne, Dr. Rycroft, Dr. Winnicott.

Lectures on ' Melanie Klein's Contribution to Theory,' Dr. Segal.

Lectures on ' Psychoses,' Dr. Bion, Dr. Rosenfeld.

Combined Course (A and B), Seminars, Dr. Bion, Mrs. Klein; Mrs. Rosenfeld; Dr. Hoffer, Dr. Lantos, Dr. Winnicott.

Seminars: Course A, Dr. Gillespie, Dr. Thorner; Dr. Heimann, Mrs. Klein. Course B, Miss Freud.

DUTCH PSYCHO-ANALYTICAL SOCIETY

(*Nederlandse Vereniging Voor Psychoanalyse*)

J. W. Brouwersplein 21, Amsterdam Z

Officers for the Year 1953–54: Chairman: Dr. H. G. van der Waals; *Secretary:* Dr. E. Frijling-Schreuder; *Treasurers:* Dr. J. Spanjaard, Dr. M. C. Mackenzie-v. d. Noordaa, Mrs. B. C. van d. Stadt-Baas.

The Dutch Psycho-Analytical Society is divided into two sub-groups, the Amsterdam and The Hague groups, both having their own administration and organizing their own lectures and research work. A lively contact, however, exists between the groups.

Scientific Research: In co-operation with the Institute, a number of our members are studying the indications and possibilities of analytic therapy, whereas some members are engaged in psychosomatic research. Work on group therapy for students is being continued.

Dr. August Staercke, honorary member of the Dutch Psycho-Analytical Society, died on 16 September, 1954.

Scientific Meetings

Dr. L. Hornstra: ' Analysis of a Borderline Case.'

Dr. H. G. van der Waals: ' Remarks on the London Congress.'

Prof. A. Querido : ' The Psychological and Social Constellation of a number of Somatic Complaints.'

Film: ' A Two-year-old goes to the Hospital.'

Prof. Alexander: ' Principles of Psychosomatic Medicine.'

Dr. S. J. Vles: ' A Case of Kleptomania.'

Mrs. G. C. Querido-Nagtegaal: ' Anamneses of Ordinary People.'

The Training Institute of the Dutch Psycho-Analytical Society

Twenty-seven candidates were in training in 1954, three of whom were elected associate members of the Society in September, 1954.

During 1954–55 the theoretical lectures and seminars covered the following themes:

First Year: Introduction to Psychoanalysis; Freud's Theory of Dreams; Freud's Three Essays on the Theory of Sexuality, Hysteria, Obsessional Neurosis.

Second Year: Technique; Perversions; The Oedipus- and Castration-Complex; Character Disturbances; Capita Selecta of Freud's Writing.

Third Year: Indications for Psychoanalytical Treatment; General Theory of Neurosis; Psychotherapy; Interplay of Neuroses of Parents and Children; Freud's Totem and Taboo; Development of Psychoanalysis during the Last Decades; Deviations from Psychoanalysis (Jung, Reik, Horney, Alexander).

A committee was appointed to revise the activities of the training committee. At the end of 1954 this committee suggested that the rules of the British Institute regarding training be adopted, except for some minor changes. This suggestion was accepted by the general meeting. The most important amendment has been the cancelling of the title of ' training analyst '.

Training Committee: R. le Coultre, R. Feith, Dr. Jeanne Lampl-de Groot, Dr. H. A. v. d. Starren (*Secretary*), Dr. H. G. van der Waals.

FRENCH PSYCHO-ANALYTICAL SOCIETY

(*Société Psychanalytique de Paris*)

187, Rue Saint-Jacques, Paris V^{e}

Le Bureau de la Société Psychanalytique de Paris est ainsi constitué pour l'année 1954: *Président:* Dr. Pierre Mâle; *Vice-Président:* Dr. Maurice Bouvet; *Membre-Assesseur:* Dr. Marc Schlumberger; *Secrétaire:* Dr. Pierre Marty; *Trésorier:* Dr. Jean Mallet.

Activités Scientifiques:

Exposé du Dr. Michel Fain sur ' Contribution à l'étude du voyeurisme.' Discussion.

Exposé du Dr. Bela Grunberger sur ' Esquisse

d'une théorie psychodynamique du masochisme.' Discussion.

Introduction par le Dr. S. Nacht d'un colloque sur ' Les critères de la fin du traitement psychanalytique.' Discussion.

Conclusions sur le colloque ' Les critères de la fin du traitement psychanalytique ' et introduction d'un colloque sur: ' La technique de la fin du traitement psychanalytique.'

Discussion du colloque sur ' La technique de la fin du traitement psychanalytique.'

XVII^e Conference des Psychanalystes de Langues Romanes

(Paris, 11, 12 et 13 novembre 1954)
160 Membres Inscrits.

Rapports

' Le Principe de sécurité ' par M. F. *Lechat* de Bruxelles. Interventions du Dr. *Winnicott*, de Mme. Marie *Bonaparte*, du Prof. *Servadio*, des Drs. *Nacht*, *Berge*, *Pasche*, *Cahen*, *Fain*, *Held.*

' Indications et contre-indications de la psychanalyse ' par les Drs. *Nacht* et *Lebovici.* Interventions de Mme. Marie *Bonaparte*, R. de *Saussure*, Melle *Nicolas* (de Nancy), des Drs. *Bartoleschi*, *Held.*

' Importance du rôle de la motricité dans la relation d'objet,' par les Drs. *Marty* et *Fain.* Interventions de Mme. Marie *Bonaparte*, des Drs. *Nacht*, *Bouvet*, *Ajuriaguerra*, *Diatkine*, *Luquet.*

Liste des Membres de la Societe Décédés depuis le mois de juillet 1953 :

Docteur Georges Parcheminey, Président de la Société.

Docteur Charles Odier, Membre Associé de la Société.

Madame Boulanger, Membre Adhérent de la Société.

Institut de Psychanalyse

Rapport d'Activité

Durant l'année 1954, l'organisation de l'Institut de Psychanalyse a été aménagée et perfectionnée. La durée des cycles d'études a été augmentée et alignée à la durée de l'année scolaire—comportant trois trimestres allant d'octobre à juillet.

Rappelons que les études comportent 3 cycles d'etudes, chacun d'une année scolaire:

(1) le cycle A—théorique—auquel le candidat accède au terme de 12 mois pleins d'analyse personelle. Il comporte des conférences et un séminaire de textes.

(2) le cycle B—clinique—comporte les conférences sur les grands syndromes psychanalytiques et un séminaire de clinique. Ce séminaire est caractérisé par la relation d'une analyse séance par séance, avec commentaires cliniques et théoriques. Il est assuré par un membre de la Commission de l'Enseignement.

(3) le cycle C—technique—comporte des conférences de technique psychanalytique et un séminaire sous la direction d'un membre de la Commission de l'Enseignement. Ce séminaire est caractérisé par la relation de deux cas thérapeutiques faite par des membres adhérents. Le Directeur du séminaire provoque et oriente la discussion et assume les commentaires cliniques et techniques que nécessite le déroulement de la cure.

Le nombre total de candidats inscrits aux trois cycles est de 46. Certains, en raison de leur expérience et de leurs titres ont été autorisés à un cumul leur permettant une accélération de leurs études.

Par des conférences extraordinaires, l'Institut de Psychanalyse a pu établir une liaison avec des personnalités variées: économistes, médecins, criminologistes, psychanalystes étrangers de passage à Paris, etc. ont été invités à traiter un sujet présentant un point de contact avec notre discipline. Des échanges féconds ont pu être établis.

C'est en Juin 1954 qu'eut lieu l'inauguration officielle de l'Institut de Psychanalyse sous la présidence de Monsieur le Ministre de l'Education Nationale. La relation de cette cérémonie a été faite en son temps.

La presence de Dr. *Ernest Jones*, doyen des premiers compagnons de Freud fut pour tous un grand honneur et une joie profonde.

Un Centre de Consultations et de Traitements Psychanalytiques est adjoint à notre organisme d'enseignement. Il fonctionne de la manière suivante: Six médecins assurent les consultations quotidiennes de triage, 17 assurent le traitement psychanalytique de 37 malades. Cette activité se trouve déjà limitée par l'insuffisance des locaux.

Les ressources du Centre de Consultations et de Traitements Psychanalytiques sont de deux ordres: Les cotisations des membres titulaires et adhérents assurent le fonctionnement matériel du Centre. Une convention passée avec la Sécurité Sociale a pour conséquence le remboursement a 80% des actes de la cure psychanalytique sur la base d'un tarif d'autorité. Ces recettes permettent de donner une indemnité au médecin traitant.

Tel est brievement esquissé le bilan des efforts poursuivis depuis la création de l'Institut de Psychanalyse. Les objectifs des années à venir sont: Le perfectionnement des études vers une orientation encore plus clinique et technique. La création d'un Centre de documentation, bibliothèque, fichier. L'extension des activités du Centre de Traitements, déjà insuffisant.

Programme de L'enseignement

du ler Octobre 1954 au 30 Juin 1955

Cycle A; Theorie Generale de la Psychanalyse:

Introduction à l'enseignement psychanalytique (Dr. Benassy); Développement de l'enfant (Dr. Mâle); Conférences extraordinaires (Mme. M. Bonaparte); Théorie des rêves (Mme. M. Bonaparte); Etude psychanalytique de la sexualité chez la femme (Mme. M. Bonaparte); Etude psychanalytique de la sexualité chez l'homme (Dr. Cénac); Mécanismes de défense du Moi (Dr. Benassy);

Instincts et développement (Dr. Pasche); Etude des conflits à l'adolescence (Dr. Berge); Psychanalyse et délinquance juvénile (Dr. Lebovici).

Séminaires de textes. Séminaire consacré a l'étude de textes freudiens: ' L'homme aux loups ' (Dr. Held).

Cycle B; Clinique Psychanalytique:

Les conferences seront groupées en 3 colloques trimestriels: Les Nevroses (Directeurs: Dr. Diatkine et Dr. Favreau); Les Psychoses (Directeurs: Dr. Pasche, Dr. Mallet et Dr. Renard); La Médicine psycho-somatique (Directeurs: Dr. Marty, Dr. Held, Dr. Fain).

Séminaire de Clinique Psychanalytique sous la direction du Dr. Bouvet.

Séminaire de Textes Psychanalytiques. Séminaire consacré à l'étude du Narcissisme (Dr. Pasche).

Cycle C; Technique Psychanalytique:

Le cours théorique du Dr. Nacht, avec la collaboration des Drs. Schlumberger, Mâle et Bouvet.

Séminaire de technique psychanalytique sous la direction du Dr. Nacht.

Séminaire de Textes Psychanalytiques. Textes de Ferenczi et de Mélanie Klein (Dr. Grunberger).

La Psychanalyse des Enfants

4 colloques consacrés à des discussions théoriques: Modes de début de la psychanalyse dite précoce (Dr. Lebovici—Mlle Doumic—Mlle Simon—Dr. Dell); Modes de début de la psychanalyse à la période de latence (Dr. Favreau—Dr. Soulé—Dr. Bensoussan); Modes de début de la psychanalyse des adolescents (Dr. Luquet—Dr. Boileau—Dr. Roumajon); Fin de la psychanalyse des enfants (Dr. Diatkine—Dr. Alby—Dr. Garcia Badarraco).

Séminaires techniques par Dr. Nguyen et Dr. Lebovici.

Séminaires de cures contrôlées (Drs. Lebovici—Diatkine—Favreau—Luquet).

GERMAN PSYCHO-ANALYTICAL ASSOCIATION

(*Deutsche Psychoanalytische Vereinigung*)

Berlin-Schmargendorf, Sulzaer Str. 3

Vorstand; Vorsitzender und Sekretär (Ausland): Dr. phil. Carl Müller-Braunschweig. *Mitglied des Vorstands:* Dr. med. Gerhard Scheunert. *Sekretär (Inland), Leiter des Unterrichtsausschusses:* Dr. med. Hans March.

Bericht

über die Tätigkeit der 'Deutschen Psychoanalytischen Vereinigung ' und ihres ' Berliner Psychoanalytischen Instituts ' über den Zeitraum von Mai 1953 bis Juni 1955.

Die Tätigkeit der Mitglieder der DPV musste sich in den jetzt bald 5 Jahren des Bestehens der Vereinigung in der Hauptsache auf die Ausbildung des Nachwuchses konzentrieren und musste die nicht der Ausbildung dienende wissenschaftliche Tätigkeit dahinter zurückstellen.

Die durchschnittliche Zahl der Hörer und Ausbildungskandidaten der Kurse des ' Berliner Psychologischen Instituts ' beträgt 10 bis 20.

Neue Mitglieder

Die neu gegründete ' Deutsche Psychoanalytische Vereinigung ' besass bei ihrer Gründung 10 ordentliche Mitglieder und 1 ausserordentliches Mitglied. Gegenwärtig besteht die Vereinigung aus 10 ordentlichen und 5 ausserordentlichen Mitgliedern.

Von dem Anfangsbestand von 10 ordentlichen Mitgliedern haben wir am 9. April 1954, Frau Margarete Steinbach, die seit März 1951 in Madrid eine neue Gruppe von Psychoanalytikern ausgebildet hat, durch den Tod verloren. Herr Heilbrun ist der Wiener Psychoanalytischen Vereinigung beigetreten.

Einführung einer Prüfung als Abschluss der Ausbildung

Wir haben uns dazu entschlossen, den Abschluss der Ausbildung und damit die Aufnahme als Mitglied in die Vereinigung durch Einführung einer mündlichen Prüfung zu erweitern.

Die Vorlesungsverzeichnisse 1953–1955
Winter Semester 1953/54

Käte Dräger: Seminar zum Thema der Uebertragung und Gegenübertragung.

Hans March: Falldarstellungen an Hand gerichtl. Gutachten.

Carl Müller-Braunschweig: Freud und Kant.

Carl Müller-Braunschweig: Uebungen zum Schrifttum der theoretischen Psychoanalyse.

Gerhart Scheunert: Spezielle Neurosenlehre.

Carl Müller-Braunschweig u. A.: Technisches Seminar.

Marie-Louise Werner: Seminar über Freuds Schriften zur Technik.

Wolfgang Schoene (a. G.): Ueber die Anwendung der Psychoanalyse auf Probleme der Ethnologie und Soziologie.

Sommer Semester 1954

Carl Müller-Braunschweig: Uebungen zum Schrifttum der theoretischen Psychoanalyse.

Marie-Louise Werner: Die Bedeutung der kindlichen Erlebnisse und Phantasien für die Neurose des Erwachsenen—auf Grund der psa. Beobachtungen und Erfahrungen.

Gerhart Scheunert: Spezielle Neurosenlehre.

Wolfgang Schoene (a. G.): Ueber die Anwendung der Psychoanalyse auf Probleme der Ethnologie und Soziologie.

Carl Müller-Braunschweig und Hans March: Technisches Seminar.

Käte Dräger: Seminar über Theorie und Analyse des Widerstandes.

Gerhart Scheunert: Seminar über zeitgenössische psa. Literatur des Auslands.

Sommer Semester 1954: Informatorische Vorlesungen

Käte Dräger : Der Traum.

Hans March: Der Psychotherapeut.

Ingeborg Kath: Zur Psychopathologie des Alltagslebens.

Marie-Louise Werner: Die Bedeutung der Kindheitserlebnisse für die Neurose des Erwachsenen.

Carl Müller-Braunschweig: Die Rolle der Eigenanalyse (Lehranalyse) in der Ausbildung des Psychoanalytikers.

Gerhart Scheunert: Die Bedeutung des Vaters im Lichte der psa. Psychologie.

Winter Semester 1954/55

Carl Müller-Braunschweig: Uebungen zur Analyse des Traumes.

Marie-Louise Werner: Theorie und Praxis der Kinderanalyse.

Gerhart Scheunert: Allgemeine Neurosenlehre.

Gerhart Scheunert: Seminar über zeitgenössische psa. Literatur des Auslands.

Wolfgang Schoene (a. G.): Seminar über die Problematik des Geschlechtscharakters.

Carl Müller-Braunschweig: Einführung in die Psychoanalyse.

Käte Dräger : Seminar über Theorie und Analyse des Widerstandes und der Uebertragung.

Carl Müller-Braunschweig und Hans March: Technisches Seminar.

Sommer Semester 1955

Carl Müller-Braunschweig: Uebungen zum Schrifttum der theoretischen Psychoanalyse.

Marie-Louise Werner: Theorie und Praxis der Kinderanalyse.

Gerhart Scheunert: Allgemeine Neurosenlehre.

Gerhart Scheunert: Seminar über zeitgenössische psychoanalytische Literatur des Auslandes.

Käte Dräger: Seminar über Freuds Krankengeschichten.

Carl Müller-Braunschweig: Einführung in die Psychoanalyse.

Horst-Eberhardt Richter: Technik der anamnestischen Exploration.

Carl Müller-Braunschweig und Hans March: Technisches Seminar.

ITALIAN PSYCHO-ANALYTICAL SOCIETY

(*Società Psicoanalitica Italiana*)

Via delle Rose 3, Bologna, Italy

Officers: President: Prof. Cesare Musatti. *Vice-President:* Prof. Emilio Servadio. *Secretary:* Dr. Egon Molinari.

Training Analysts: Dr. C. Modigliani, Prof. C. Musatti, Prof. N. Perrotti, Prof. E. Servadio, Mrs. A. Tomasi di Palma.

XVIe Conférence des Psychanalystes de Langues Romanes (XVIth Conference of the Psychoanalysts of Romance Languages).

This Conference was organized by the Italian Psychoanalytic Society in co-operation with the Société Psychanalytique de Paris. It was held in Rome from 21–24 September, 1953. Several Italian, French, Belgian and South American analysts participated. Reports were presented by Prof. E. Servadio (' Function of Pre-oedipal Conflicts '), Drs. S. Lebovici and R. Diatkine (' Study of the Phantasms in the Child ') and Dr. Pasche (' Anxiety and the Freudian Theory of Instincts '). A lecture, accompanied by a film, was given by Dr. R. Spitz of New York.

Other Conferences

The Italian Psychoanalytic Society was represented by some of its members at the International Congress of Psychotherapy (Zurich, 1954), at the 17th Conference of the Psychoanalysts of Romance Languages (Paris, 1954), and at the 10th Convention of Italian Psychologists (Chianciano, 1954).

Conferences of Candidates

Candidates in advanced training have convened twice to discuss special analytical problems: ' The Preconscious ' and ' Counter-Transference'. Senior analysts attended sessions of both Conferences.

Seminars

Seminars on ' Dreams ' (Prof. N. Perrotti), ' Perversions ' (Prof. E. Servadio) and ' Clinical Psychoanalysis ' (Prof. C. Musatti, Prof. N. Perrotti, Prof. E. Servadio) were held in Rome and Milan for candidates in training.

A Seminar on Child Analysis was held by Dr. S. Lebovici (by invitation).

Candidates in Training

By April, 1955, the Italian Psychoanalytic Society had 12 candidates undergoing personal analysis, and about 20 candidates in advanced training or doing control work.

Bulletin

An official Bulletin of the Italian Psychoanalytic Society was started in 1954.

Lectures

Several lectures on analytic subjects were given in Italian Universities and to learned societies by Prof. C. Musatti, Prof. E. Servadio and Prof. N. Perrotti. Prof. Servadio also lectured on several occasions on the Italian Radio.

Members of other Component Societies have visited the Italian Psychoanalytic Society, and some of them have given lectures or held short seminars. From the United States came Dr. D. Rapaport, Dr. L. Eidelberg, Dr. J. Eisenbud, Dr. S. Lorand, Dr. A. Maenchen, Mrs. L. Peller. From the United Kingdom, Dr. H. K. Thorner.

SWEDISH PSYCHO-ANALYTICAL SOCIETY

(Svenska Psykoanalytiska Foreningen)

Officers: Nils Haak, M.D. (*Chairman*); Gosta Harding, M.D. (*Vice-Chairman*); Tore Ekman, lektor (*Secretary*); Erik Reinius, M.D. (*Treasurer*); Lajos Szekely, Ph.D. (*Librarian*).

Vortraege

Dr. Højer-Pedersen: 'Psychoanalytische Gesichtspunkte zur Genese der Ulcuskrankheit.'

Therese Merzbach: 'Ein Fall von Transvertitismus.'

Magister Ola Andersson: 'Einige Zuege in der fruehen wissenschaftlichen Entwicklung Freuds im Lichte seiner Korrespondenz mit Fliess.

Dr. Torsten Sjovall: 'Ein psychosomatischer Fall.'

Fil. lic. Anna-Stina Rilton: 'Agieren als magische Abwehr bei einem zwangsneurotischen Mann.

Dr. Lajos Szekely: 'Zur Entstehung der Latenzzeit.'

Dr. Nils Haak: 'Einige Gesichtspunkte zur Uebertragung.'

Magister Stefi Pedersen: 'Psychoanalyse eines Falles mit Obsessionen.'

Dr. Bjerg Hansen: 'Arztberuf und Neurose.'

Seminarien

Herbst 1954: Klinisches Seminar (Ekman). Klinisches Seminar (Haak). Theoretisches Seminar (Lajos Szekely).

Fruehling 1955: Klinisches Seminar (Ekman). Klinisches Seminar (Haak). Theoretisches Seminar (Lajos Szekely).

Anzahl der Ausbildungskandidaten: 16, wovon 5 in der Sitzung vom 10 Juni 1955 ausserordentliche Mitglieder geworden sind.

SWISS PSYCHO-ANALYTICAL SOCIETY

(Schweizerische Gesellschaft für Psychoanalyse)

Officers: Präsident: Dr. Philipp Sarasin. *Kassier:* Dr. H. Bänziger. *Aktuar:* Dr. Hans Zulliger. *1. Beisitzer:* Mlle M. Rambert. *2. Beisitzer:* Dr. Raymond de Saussure. *Bibliothekar:* Dr. Medard Boss.

Sitzungen;

Vorstandssitzungen	1
Geschäftssitzungen	7
Wissenschaftliche Sitzungen	9

Wissenschaftliche Arbeiten

Dr. h. c. Hans Zulliger: 'Blitzheilung.'

Dr. M. Emery: 'A propos d'une tranche d'analyse d'un homosexuel latent.'

Prof. Dr. E. Schneider: 'Inzestneigung und Inzestschranke in Leben, Neurose und Mythos.'

Mme. Germaine Guex: 'Sens du symptôme et de sa disparation dans un cas de colite ulcéreuse.'

Dr. med. A. Friedemann: 'Psychotherapeutische Grundhaltung und Gutachtertätigkeit.'

Dr. med. G. R. Reding: 'Un cas d'impuissance.'

Direktor Dr. med. A. Kielholz: 'Vom Kairos. Zum Problem der Kurpfuscherei.'

Madame M. Séchehaye: 'Analyse d'une nevrose traumatique chez une femme de 60 ans.'

Prof. Dr. med. E. Krapf: 'Ueber die Sprachwahl in der Psychoanalyse von Polyglotten durch Polyglotte.'

VIENNA PSYCHO-ANALYTICAL SOCIETY

(Wiener Psychoanalytische Vereinigung)

Jahresbericht 1954/55 für die Generalversammlung am 20. April 1955

Vorstand: Dr. Alfred Winterstein (*Obmann*); Dr. Wilhelm Solms (*Sekretär*); Dr. Lambert Bolterauer (*Kassier*).

Das abgelaufene Vereinsjahr 1954/55 stand im Zeichen zweier Freud-Feiern. Am Vorabend der Enthüllung der Gedenktafel an Professor Freuds ehemaligem Wohnhaus, am 5. Mai 1954, hielt Obmann Dr. Winterstein in der Vereinigung vor geladenen Gästen einen Festvortrag über 'Die inneren Beziehungen des Menschen und Forschers Freud zu Goethe'. Anschliessend fand ein Bankett im Rathauskeller statt. Am 6. Mai wurde vormittags die Enthüllung der Gedenktafel vorgenommen. Nach Professor Dr. *Ruemke* (Utrecht), dem Präsidenten der World Federation for Mental Health und Initiator der Freud-Ehrung, Professor Dr. *Hoff* und dem Vertreter des Bürgermeisters der Stadt Wien sprach Obmann Dr. *Winterstein.*

In der zweiten Hälfte Mai übersiedelte Dr. Hans *Aufreiter* nach Montreal (Kanada), um in der Kanadischen Psychoanalytischen Gesellschaft als Lehranalytiker tätig zu sein. Frau Dr. *Aufreiter* folgte ihm Anfang Juli. Die durch das Ausscheiden Dr. Hans Aufreiters freigewordene Stelle im Lehrausschuss übernahm das Ersatzmitglied, Dr. Tea *Genner-Erdheim.*

Da die zur Ernennung als Lehranalytiker ursprünglich festgesetzten strengen Bedingungen von der seit längerer Zeit gepflegten Praxis inzwischen überholt wurden, erfolgte in der a. o. Generalversammlung vom 21. September eine Neuregelung. Sie besagt, dass der Lehrausschuss Mitglieder zu Lehranalytikern bestellen kann, die als ordentliche Mitglieder mindestens fünf Jahre klinische Erfahrung in der Psychoanalyse haben. Der Lehrausschuss behält sich das Recht vor, ausnahmsweise einen Analytiker mit weniger als fünf Jahren klinischer Erfahrung im Lehrplan zu beschäftigen, wenn seine Arbeit hohen Anforderungen entspricht und ein dringender Bedarf besteht. Bisher hatten nur Obmann Dr. Winterstein und Dr. Hans Aufreiter den Status eines Lehranalytikers. Es wurden nunmehr auch zu Lehranalytikers ernannt: Dr. Solms, Dozent Dr. Bolterauer und Frau Dr. Bolterauer, Dr. Genner-Erdheim, und Frau Dr. Aufreiter.

Am 4. Februar wurde die von Dr. Ernest Jones

gespendete Büste Professor Freuds im Arkadenhof der Universität Wien enthüllt. Die Kosten des Sockels waren von den Mitgliedern und Kandidaten der Vereinigung aufgebracht worden. Am Vorabend gab die Vereinigung zu Ehren der ausländischen Gäste (Prof. Dr. E. *Krapf* aus Buenos-Aires samt Frau und Dr. Leo *Bartemeier* aus U.S.A.) ein Bankett im Rathauskeller. Der eigentliche Festakt fand am Morgen des folgenden Tages im grossen Festsaal der Universität statt. Nach der Ansprache des Rektors, Prof. Dr. Johann *Radon*, des Dekans, Prof. Dr. Franz *Brücke*, Professor *Hoffs*, Professor *Krapfs* und Dr. *Bartemeiers* hielt Obmann Dr. *Winterstein* einen Vortrag über ' Leben und Wirken Freuds'. Zum Abschluss nahm der Rektor das Denkmal in den Ehrenschutz der Universität; auch die Vereinigung legte einen Kranz am Sockel nieder.

Am 11. Februar wurde Dr. Margarete *Stepan* zum a. o. Mitglied gewählt. Frau Dr. Stepan folgte einer Berufung durch die Weltgesundheitsorganisation nach Bangkok (Thailand), wo sie bei der Einrichtung einer Childguidance-Klinik mitwirken, als klinische Psychologin tätig sein und klinische Psychologen ausbilden soll.

Die Zahl der ordentlichen Mitglieder beträgt derzeit einschliesslich der im Ausland weilenden Mitglieder fünfzehn. Dr. Theon *Spanudis* wird auf Grund eines Beschlusses der Generalversammlung vom 27. April 1954 nicht mehr als Mitglied geführt.

Die Zahl der ausserordentlichen Mitglieder beläuft sich auf vier. Dr. Hans *Hoff* ist Ehrenmitglied. Ausbildungskandidaten: 15.

Vorlesungen und Seminare Sommersemester 1954

Für Ausbildungskandidaten:

Dr. Alfred Winterstein: Spezielle Neurosenlehre.
Dozent Dr. Lambert Bolterauer: Freud Seminar.
Dr. Hans Aufreiter: Kasuistisches Seminar.

Im Rahmen der August-Aichhorn-Gesellschaft

Dr. Erich Heilbrun: ' Einführung in die Psychoanalyse.'
Dr. Wilhelm Solms: ' Trunksucht bei Frauen '.

Wintersemester 1954/55

Für Ausbildungskandidaten :

Dr. Alfred Winterstein: ' Analytische Normalpsychologie '; ' Allgemeine Neurosenlehre '.
Dozent Dr. Lambert Bolterauer: Freud Seminar.
Dr. Tea Genner-Erdheim: Kasuistisches Seminar.

Im Rahmen der August-Aichhorn-Gesellschaft

Dr. Erich Heilbrun: ' Einführung in die Psychoanalyse '.
Dr. Alfred Winterstein: ' Zur Prophylaxe der Neurosen.'
Frau Rosa Dworschak: ' Die Pflegeeltern und ihre Probleme.'

ASIA

INDIAN PSYCHO-ANALYTICAL SOCIETY

14 Parsibagan Lane, Calcutta 9, India

Report for 1954

Members and Associates. The number of Members was 20 and the number of Associate Members was 25.

Business Meetings. The 32nd Annual Meeting was held on 23 March, 1954. The office-bearers, Council of the Society, Board of the Institute and various Committees were elected for the year 1954.

Officers: Dr. S. C. Mitra (*President*); Mr. T. C. Sinha (*Secretary*); Mr. M. K. Barua (*Librarian*); Mr. A. Datta (*Asst. Secretary*); Dr. D. N. Nandi (*Asst. Secretary*); Mrs. H. Gupta (*Asst. Librarian*).

Council of the Society: Mr. M. V. Amrith, Mr. M. K. Barua, Dr. N. De, Mr. H. P. Maiti, Dr. S. C. Mitra, and Mr. T. C. Sinha.

Board of the Institute: Dr. N. De, Mr. B. Desai, Mr. H. P. Maiti, Dr. S. C. Mitra, Dr. K. L. Shrimali and Mr. T. C. Sinha.

Journal Committee: Mr. M. V. Amrith, Dr. B. K. Bose, Dr. N. N. Chatterjee, Mr. A. Datta, Dr. N. De, Dr. A. K. Dev, Dr. S. C. Mitra, and Mr. T. C. Sinha.

Scientific Meeting. Dr. N. N. Chatterjee read a paper on ' Object Choice in Hysterical Women '.

Social Activity. The members of the Society met Mrs. Anna Maenchen, Ph.D., Vice-President of the San Francisco Psychoanalytic Institute, at a tea party given by the Society on 18 December, 1954. Dr. Maenchen and Dr. Rech were also present.

Indian Psycho-Analytical Institute. One candidate was admitted ; number of candidates in training 8, two of whom were doing control work.

Training and Control Analysts: Dr. N. De, Dr. Edith Ludowyk-Gyomroi, Mr. H. P. Maiti, Dr. S. C. Mitra and Mr. T. C. Sinha.

Training Analysts: Mr. M. V. Amrith, Mr. R. M. Patel and Dr. K. L. Shrimali.

33rd Annual General Meeting (29 March, 1955)

The following office-bearers, members of the Council, Board of the Institute and various Committees were elected for the year 1955:

Officers: Dr. S. C. Mitra (*President*); Mr. T. C. Sinha (*Secretary*); Mr. M. K. Barua (*Librarian*); Mr. A. Datta (*Asst. Secretary*); Dr. D. N. Nandi (*Asst. Secretary*); Mrs. Hashi Gupta (*Asst. Librarian*).

Council of the Society: Mr. M. V. Amrith, Mr. M. K. Barua, Dr. N. De, Mr. H. P. Maiti, Dr. S. C. Mitra, and Mr. T. C. Sinha.

Board of the Institute: Mr. B. Desai, Dr. N. N. Chatterji, Dr. N. De, Mr. H. P. Maiti, Dr. S. C. Mitra, and Mr. T. C. Sinha.

Journal Committee: Mr. M. V. Amrith, Dr. B. K. Bose (*Asst. Editor*), Dr. N. N. Chatterjee, Mr. A. Datta, Dr. N. De (*Editor*), Dr. A. K. Dev, Dr. S. C. Mitra, C. V. Ramana and T. C. Sinha.

ISRAEL PSYCHO-ANALYTICAL SOCIETY

(*Chewrah Psycho-Analitit B'Israel*)

Report for the Period May, 1953–May, 1955

In den letzten Jahren hat das Interesse an der Analyse und ihre Anerkennung in ganzen Lande erheblich zugenommen. Das kam zum Ausdruck in der Bitte an unsere Mitglieder um Mitarbeit an verschiedenen Behandlungs und Beratungsstellen und der intensiven Zusammenarbeit mit der Medical School der Hebraeischen Universitaet, Jerusalem. Drei unserer Kollegen: Dr. Gumbel, Professor Rothschild und Professor Winnik halten Vorlesungen und Seminare fuer die Medizinstudenten ab und beschaeftigen sich besonders mit der Ausbildung junger Psychiater. Die Zahl der Psychiater, die sich bei uns zur Ausbildung in der Psychoanalyse meldeten, ist sehr gestiegen. Diese erfreuliche Zunahme ist zum Teil zuzuschreiben der Entwicklung der Psychiatrischen Abteilung der Medical School der Hebraeischen Universitaet, zum Teil der Errichtung des 'Eitingon-Fonds', den Professor Milton Rosenbaum (Cincinnati) aus Beitraegen unserer amerikanischen Kollegen gesammelt hat. Dieser Fond gibt den von unserer Gesellschaft als Ausbildungskandidaten anerkannten Kollegen Anleihen zur Finanzierung ihrer Trainingsanalysen.

Es sind zur Zeit 16 Kandidaten in Ausbildung, darunter 3 Laien, die schon seit vielen Jahren mit der Vereinigung verbunden sind und in verschiedenen Institutionen mit Kindern und Jugendlichen arbeiten. Sie werden demnaechst als Mitglieder aufgenommen werden, mit der Verpflichtung, sich auf dieses Gebiet zu beschraenken.

Es besteht die Tendenz in steigendem Masse, nur Aerzte aufzunehmen, und die Formulierung entsprechender Statuten ist in Vorbereitung.

Ein wichtiges Ereignis fuer uns war die Uebersiedlung des Instituts in neue Raeume in der Disraelistr. 13.

Trainingskomitee: bestehend aus Dr. Barag, Dr. Brandt, Dr. Gumbel, Frau Weiss-Statthagen, Prof. Winnik.

Lehrberechtigung haben: Dr. Barag, Dr. Brandt, Dr. Gruenspan, Dr. Gumbel, Dr. Lowtzky, Dr. Smiliansky, Prof. Winnik und Dr. Wulff.

Professor George Mohr (aus Chicago), der fuer ein Jahr als Direktor des Lasker-Centres der Hadassah herkam, uebernahm waehrend dieser Zeit die Kontrolle der Kinderfaelle unserer Kandidaten.

Es wurden folgende Kurse und Seminare abgehalten: fuer Kandidaten:

In Jerusalem: Dr. Brandt: Gruppenbesprechungen laufender Behandlungen. Dr. Gumbel: Technisches Seminar. Prof. Winnik: Literaturseminar ueber Ich-Psychologie.

In Tel-Aviv: Dr. Wulff: Literaturseminar.

In allen Staedten wurde die Arbeit von Heilpaedagogen und 'case workers' kontrolliert.

Wissenschaftliche Vortraege

Dr. Bental: 'Pathogenitaet von Zwillingstum Schwestern.'

Dr. Kainer: 'Fall von Neurose und Perversion.'

Prof. Rosenbaum (als Gast): 'Die Wichtigkeit frueherer Erinnerungen in der Aufnahmebesprechung.'

Prof. Schur (Gast): 'Angst und Ich-Entwicklung.'

Dr. Silberman (Gast): 'Ich-Entwicklung.'

Dr. Haas: 'Analyse einer Depression.'

Dr. Zellermayer: 'Erfahrungen mit psychosomatischen Patienten im Krankenhaus.'

Dr. Lowtzky: 'Wirkliche und neurotische Agression.'

Prof. Winnik: 'Eindruecke ueber die beiden analytischen Richtungen in England.'

Dr. Rothschild: 'Unechtheit und Unsicherheit des Selbst als Basis fuer psychische Erkrankung.'

Alice Weiss: 'Teil einer Kinderanalyse.'

Peller (Gast): 'Libido Stufen und Spielentwicklung.'

Dr. Maenchen (Gast): 'Einige Bemerkungen ueber die Psychologie des Analytikers.'

Dr. Peler: 'Neue Forschungsergebnisse in der Psychologie junger Kinder, gegruendet auf psychoanalytische Theorie.'

Dr. Wulff: 'Ich-Identifizierung und Triebleben.'

Von unseren Mitgliedern verstarb Dr. Idelson, Tel Aviv, am 19.10.1954.

SENDAI PSYCHOANALYTIC SOCIETY (JAPAN)

Heisaku Kosawa, M.D., was elected in July, 1954, to succeed the late Dr. Kiyoyasu Marui, as President of the Sendai Psycho-Analytical Society.

1. Activities of the Sendai Psychoanalytic Society since 1953:

(*a*) Academic: Lecture courses have been organized at the Hirosaki and the Hiroshima Universities on psychoanalysis, as part of the study of psychopathology.

(*b*) Training: Technical guidance has been given to members of the faculties.

2. Activities of the Psychoanalytic Research Institute (Tokyo):

(*a*) Academic: Monthly meeting: Lectures on basic theories; study of individual cases; publication of a monthly organ called Seishin Bunseki Kankyu (The Psycho-analytic Research).

(*b*) Educational: Six men (one from the Kyushu University and five from the Keio University) are under educational training.

(*c*) Other activities: There is a group for academic studies of psycho-analysis. Faculty members of the Kyushu and the Niigata Universities are its nucleus.